UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

MEDIANT HEALTH RESOURCES, INC

Group Number: GA2U8176NM **Health Plan:** CD - IV **Prescription Code:** F25
Effective Date: December 1, 2021

Offered and Underwritten by
UnitedHealthcare Insurance Company

Riders, Amendments, and Notices

begin immediately following the last page

of the Certificate of Coverage

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Health Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Benefits.*
- The Group's *Application.*
- Riders, including the *Outpatient Prescription Drug Rider*, the *Pediatric Dental Services Rider* and the *Pediatric Vision Care Services Rider*.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate.* When this happens we will send you a new *Certificate,* Rider or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends.*

We are delivering the Policy in Arizona . The Policy is subject to the laws of the state of Arizona and ERISA, unless the Group is not a private plan sponsor subject to ERISA. To the extent that state law applies, Arizona law governs the Policy.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms.*

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference. You can also get this *Certificate* at www.myuhc.com.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Care Services* and *Section 2: Exclusions and Limitations.* Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins.* To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms.*

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Health Care Services

The Policy does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Physician. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver your care. You may schedule an appointment directly with a Specialist; however, Covered Health Care Services are payable at a higher Benefit level from Network providers, and Covered Health Care Services obtained from out-of-Network providers are payable at a lower Benefit level. The amount you pay for Covered Health Care Services is described in the Schedule of Benefits.

We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Care Services require prior authorization. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Care Services from an out-of-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Care Services that require prior authorization, please refer to to the section titled *"Does Prior Authorization Apply?"* in the *Schedule of Benefits.*

Pay Your Share

You must meet any applicable deductible and pay a Co-payment and/or Co-insurance for most Covered Health Care Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Benefits.* You must also pay any amount that exceeds the Allowed Amount.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim.*

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health care services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under the Policy for all other Covered Health Care Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Care Services

We pay Benefits for Covered Health Care Services as described in *Section 1: Covered Health Care Services* and in the *Schedule of Benefits,* unless the service is excluded in *Section 2: Exclusions and Limitations.* This means we only pay our portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim.*

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, as we determine, in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As indicated in the most recent edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* for the diagnosis and treatment of Mental Illnesses and alcoholism and Substance-Related and Addictive Disorder Services.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service

billed. You may get copies of our reimbursement policies for yourself or to share with your out-of-Network Physician or provider by contacting us at www.myuhc.com or the telephone number on your ID card.

We may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Care Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Care Service. If the methodology(ies) currently in use become no longer available, we will use a comparable methodology(ies). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for informatio n regarding the vendor that provides the applicable methodology.

Offer Health Education Services to You

We may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to take part in the programs, but we recommend that you discuss them with your Physician.

Certificate of Coverage Table of Contents

Section 1: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary, or if the supplies/services are mandated by state or federal law. (See definitions of Medically Necessary and Covered Health Care Service in *Section 9: Defined Terms.)*
- You receive Covered Health Care Services while the Policy is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Policy.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Annual Deductible, Per Occurrence Deductible, Co-payment and/or Co-insurance).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount you are required to pay in a year (Out-of-Pocket Limit).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Outpatient Facility Charges: Benefits are available for the facility charge and related charge for supplies and equipment for Covered Health Care Services. Depending upon where the Covered Health Care Service is provided, Benefits for outpatient facility charges will be the same as those stated under each Covered Health Care Service category in the *Schedule of Benefits.*

1. Ambulance Services

Emergency ambulance services, without prior authorization, to the nearest Hospital or other facility that is licensed or otherwise authorized to furnish Emergency Health Care Services.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground, air or water ambulance, as we determine appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required.
- To the closest Network Hospital that provides the required Covered Health Care Services that were not available at the original Hospital.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility where the required Covered Health Care Services can be delivered.

For the purpose of this Benefit the following terms have the following meanings:

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

- "Ambulance" means any publicly or privately owned surface, water or air vehicle, including a helicopter, that contains a stretcher and necessary medical equipment and supplies pursuant to *Arizona Revised Statutes Section 36-2202* and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. Ambulance does not include a surface vehicle that is owned and operated by a private sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in-transit care of its employees or a vehicle that is operated to accommodate an incapacitated person or person with a disability who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or ambulance attendants.
- "Emergency ambulance services" means services provided by an ambulance service authorized to operate pursuant to *Arizona Revised Statutes* Title 36, Chapter 21.1 following the onset of a medical condition that manifests itself by symptoms of pain, illness, or Injury that the absence of accessing an ambulance or emergency response by calling 911 or a designated telephone number to reach a public safety answering point and receiving time sensitive medical attention could reasonably be expected to result in any of the following:
    - Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.
- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services.*

3. Clinical Trials

Routine patient care costs incurred while taking part in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this Benefit, a life-threatening disease or condition is one which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening, when we determine the clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from taking part in a qualifying clinical trial.

Benefits are available only when you are clinically eligible, as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

- Covered Health Care Services required solely for the following:
  - The provision of the Experimental or Investigational Service(s) or item.
  - The clinically appropriate monitoring of the effects of the service or item, or
  - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain *Category B* devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI).)*
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
  - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
  - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
  - The *Department of Veterans Affairs,* the *Department of Defense* or the *Department of Energy* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation takes place under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards *(IRBs)* before you are enrolled in the trial. We may, at any time, request documentation about the trial.
- With respect to a clinical trial for the treatment of cancer, the personnel providing the treatment or conducting the study are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training, and volume of patients treated to maintain expertise.

4. Congenital Heart Disease (CHD) Surgeries

CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as:

- Coarctation of the aorta.
- Aortic stenosis.
- Tetralogy of fallot.
- Transposition of the great vessels.
- Hypoplastic left or right heart syndrome.

Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services.*

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for *CHD* services.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is needed because of accidental damage.
- You receive dental services from a Doctor of Dental Surgery, Doctor of Medical Dentistry or Physician.

Dental services are covered for the treatment of a fractured jaw or an Injury to sound natural teeth, Benefits for treatment of accidental Injury include, but are not limited to, the following:

- Emergency exam.
- Diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to Injury with implant, dentures or bridges.

6. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals. Benefits for diabetes self-management training include training, after the initial diagnosis, in the care and management of diabetes, including proper use of diabetes equipment and supplies.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes, and to the

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes.

Benefits are available for therapeutic shoes for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history or pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment (DME), Orthotics and Supplies.* Benefits for diabetic supplies are described under the *Outpatient Prescription Drug Rider* and include the following:

- Blood glucose monitors, including continuous glucose monitors.
- Blood glucose monitors for the legally blind.
- Test strips for glucose monitors and visual reading and urine testing strips.
- Insulin preparations and glucagon.
- Insulin cartridges.
- Drawing up devices and monitors for the visually impaired.
- Injection aids.
- Insulin cartridges for the legally blind.
- Syringes and lancets, including automatic lancing devices.
- Prescribed oral agents for controlling blood sugar.
- To the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes.
- Any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

7. Durable Medical Equipment (DME), Orthotics and Supplies

Benefits are provided for DME and certain orthotics and supplies. If more than one item can meet your functional needs, Benefits are available only for the item that meets the minimum specifications for your needs. If you purchase an item that exceeds these minimum specifications, we will pay only the amount that we would have paid for the item that meets the minimum specifications, and you will be responsible for paying any difference in cost.

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a wheelchair.
- A Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under *Diabetes Services.*
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate.*

Benefits include lymphedema stockings as required by the *Women's Health and Cancer Rights Act of 1998.*

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly due to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits.*

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Medical Supplies and Equipment.*

These Benefits apply to external DME. Unless otherwise excluded, items that are fully implanted into the body are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

8. Emergency Health Care Services - Outpatient

A screening exam and services that are required to stabilize or begin treatment in an Emergency including the assessment and stabilization of a psychiatric emergency medical condition. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Care Services do not require prior authorization.

Benefits include the facility charge, supplies and all professional services required to stabilize your condition and/or begin treatment. This includes placement in an observation bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits are not available for services to treat a condition that does not meet the definition of an Emergency.

9. Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment;
- Chronic physical disability;
- Intellectual disability; or
- Loss of life.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

10. Gender Dysphoria

Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician.

For the purpose of this Benefit, "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

11. Habilitative Services

For purposes of this Benefit, "habilitative services and devices" means Skilled Care services that are part of a prescribed treatment plan or maintenance program to help a person with a disabling condition to keep, learn or improve skills and functioning for daily living. Devices means Benefits for DME and prosthetic devices, when used as a part of habilitative services, are described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices.* We will decide if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services.

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

Benefits are provided for habilitative services for both inpatient services and outpatient therapy when you have a disabling condition when both of the following conditions are met:

- Treatment is administered by any of the following:
  - Licensed speech-language pathologist.
  - Licensed audiologist.
  - Licensed occupational therapist.
  - Licensed physical therapist.
  - Physician.
- Treatment must be proven and not Experimental or Investigational.

The following are not habilitative services:

- Custodial Care.
- Respite care.
- Day care.
- Therapeutic recreation.
- Vocational training.
- Residential Treatment.
- A service that does not help you meet functional goals in a treatment plan within a prescribed time frame.
- Services solely educational in nature.
- Educational services otherwise paid under state or federal law.

We may require the following be provided:

- Treatment plan.
- Medical records.
- Clinical notes.
- Other necessary data to allow us to prove that medical treatment is needed.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

When the treating provider expects that continued treatment is or will be required to allow you to achieve progress that is capable of being demonstrated, we may request a treatment plan that includes:

- Diagnosis.
- Proposed treatment by type, frequency, and expected duration of treatment.
- Expected treatment goals.
- Frequency of treatment plan updates.

Habilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Habilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

12. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). These are electronic amplifying devices designed to bring sound more effectively into the ear. These consist of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased due to a written recommendation by a Physician. Benefits are provided for the hearing aid and associated fitting charges and testing. The following are Covered Health Care Services:

- New or replacement hearing aids no longer under warranty.
- Cleaning or repair.
- Batteries for cochlear implants.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, we will pay only the amount that we would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Services categories in this *Certificate.* They are only available if you have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
- Hearing loss severe enough that it would not be remedied by a wearable hearing aid.

13. Home Health Care

Services, including habilitative and rehabilitative services, received from a Home Health Agency that are all of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, Intermittent Care schedule.
- Provided when Skilled Care is required.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

14. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care services include inpatient care, outpatient services, professional services of a Physician, services of a psychologist, social worker or family counselor for individual and family counseling, and home health care. Hospice care also includes the following:

- Physical, psychological, social, spiritual and respite care for the terminally ill person.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

- Short-term grief counseling for immediate family members while you are receiving hospice care.

Benefits are available when you receive hospice care from licensed hospice agency.

You can call us at the telephone number on your ID card for information about our guidelines for hospice care.

15. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Surgical services.
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*
- Medically Necessary implantable devices/prostheses. Implantable devices/prostheses are permanent or temporary internal aids and supports for non-functional body parts. This includes testicular implants following Medically Necessary surgical removal of the testicles. Benefits are also available for repairs, maintenance, or replacement of covered implementable devices/prostheses when Medically Necessary.
- Private hospital rooms and/or Private Duty Nursing when determined to be Medically Necessary by us.

16. Lab, X-Ray and Diagnostic - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*
- With respect to men, Benefits for prostate specific antigen (PSA) screening and digital rectal exam are provided annually if the following criteria is met:
    - For a man under 40 years of age who are at high risk because of any of the following:
        - Family history (i.e. multiple first-degree relatives diagnosed at an early age).
        - African-American race.
        - Previous borderline PSA levels.
    - For a man age 40 and older.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services.*

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

17. Major Diagnostic and Imaging - Outpatient

Services for CT scans, PET scans, MRI, MRA, Brain Electrical Activity Mapping (BEAM), Electroconvulsive therapy (ECT), nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

18. Mental Health Care and Substance-Related and Addictive Disorders Services

Mental Health Care and Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider. Mental Health Care Services and Substance-Related and Addictive Disorders Services received from a Primary Care Physician are subject to the *Physician's Office Services - Sickness and Injury* cost share as noted in the *Schedule of Benefits* and not the *Mental Health Care and Substance-Related and Addictive Disorders Services* cost share.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning, including neuropsychological testing.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.
- Psychiatric Service.
- Detoxification.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavior Analysis (ABA))* that are the following:
  - Focused on the treatment of core deficits of Autism Spectrum Disorder.
  - Provided by a *Board Certified Behavior Analyst (BCBA)* or other qualified provider under the appropriate supervision.
  - Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

  Covered Health Care Services for Autism Spectrum Disorder received from a Primary Care Physician are subject to the *Physician's Office Services - Sickness and Injury* cost share as noted in the *Schedule of Benefits* and not the *Mental Health Care and Substance-Related and Addictive Disorders Services* cost share.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this *Certificate.*

Benefits for short-term outpatient rehabilitation services included in an outpatient facility or Physician's office that is part of a rehabilitation program for treatment of Autism Spectrum Disorder, including physical, speech and occupational therapy, are described under *Rehabilitation Services - Outpatient Therapy.*

The Mental Health/Substance-Related and Addictive Disorders Designee provides administrative services for all levels of care.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

19. Obesity - Weight Loss Surgery

Benefits for obesity - weight loss surgery are provided when all criteria below are met. Benefits are limited to the following procedures:

- Open roux-en-y gastric bypass (RYGBP).
- Laparoscopic roux-en-y gastric bypass (RYGBP).
- Laparoscopic or open adjustable gastric banding (LAGB).
- Laparoscopic or open biliopancreatic diversion and a duodenal switch (BPD/DS).
- Laparoscopic or open sleeve gastrectomy (SG).
- Laparoscopic or open gastric bypass procedures.

All of the following criteria must be met in order for you to qualify for Benefits for obesity - weight loss surgery:

- Be 18 years or older, or have reached full expected skeletal growth. If the surgical candidate is less than 18 years of age, qualification can be granted if body development consistent with Tanner state 4 is present and 95% of adult height has been reached.
- Have a body-mass index (BMI) equal to or greater than 35 and have at least one significant co-morbidity related to obesity. If the body-mass index (BMI) is equal to or greater than 40, no co-morbidity is required in order to qualify for surgery. (Co-morbidity is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.) Examples of co-morbidities include type 2 diabetes, hypertension which is not adequately controlled with pharmacotherapy and moderate to severe obstructive sleep apnea, as defined on the Apnea/Hypopnea Index (AHI). Please note that back pain, knee pain and gastroesophageal reflux (GERD) do not qualify as significant co-morbidities.
- Have been previously unsuccessful with medical treatment for obesity as described below. The following medical information must be documented in your medical record:

  Have actively participated (within the last two years) in one Physician-supervised weight-management program for minimum of six months without significant gaps (defined as no dietary visits for greater than 2 months). The weight-management program must include monthly documentation of all of the following components:

  - Weight.
  - Current dietary program.
  - Physical activity, such as an exercise program.

If treatment was directly paid or covered by another plan, Benefits will be provided for Medically Necessary adjustments including Benefits for all complications (excluding the ability to lose weight, which is not a complication of surgery).

As noted above, Benefits are provided for the treatment of actual surgical complications. (Complications are defined as unexpected or unanticipated condition superimposed on an existing disease affecting or modifying the prognosis of the original disease or condition, for example, bleeding or infections that requires hospitalization.)

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

Failure of a medical or surgical treatment to achieve its desired objective, of itself, is not a complication. Failure to lose weight, of itself, is not a complication.

20. Ostomy Supplies

Benefits for ostomy supplies include but are not limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.
- Gauze, adhesive, adhesive remover, deodorant, pouch covers and other supplies when determined Medically Necessary.

21. Pharmaceutical Products - Outpatient

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by us), are administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this *Certificate.* Benefits for medication normally available by a prescription or order or refill are provided as described under your *Outpatient Prescription Drug Rider.*

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to get your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

22. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical services received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

23. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

Benefits include nutritional evaluation and counseling provided by a Physician when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including: morbid obesity, diabetes, cardiovascular disease, hypertension, kidney disease, eating disorders, gastrointestinal disorders, food allergies and hyperlipidemia.

Covered Health Care Services include outpatient contraceptive services, which include consultations, exams, procedures and medical services related to the use of United States *Food and Drug Administration (FDA)* approved prescription contraceptive methods to prevent unintended pregnancies.

Covered Health Care Services include Genetic Counseling.

Benefits include allergy injections and antigen administration and desensitization administration. Benefits for allergy testing are provided under *Lab, X-Ray and Diagnostic - Outpatient.*

Covered Health Care Services for preventive care provided in a Physician's office are described under *Preventive Care Services.*

- Hearing exam when received as part of an annual physical exam. When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services.*
- Routine vision screening when received as part of an annual physical exam. When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services.*

Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Major Diagnostic and Imaging - Outpatient.*

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a lab, radiology/X-ray or other diagnostic service, whether performed in or out of the Physician's office, are described under *Lab, X-ray and Diagnostic - Outpatient.*

24. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Care Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are voluntary and there is no extra cost for taking part in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the expected date of delivery. It is important that you notify us regarding your Pregnancy.

We will pay Benefits for an Inpatient Stay or birthing center of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Benefits are available for maternity-related medical, Hospital and other Covered Health Care Services for the birth of any child legally adopted by the Subscriber if all of the following are true:

- The child is adopted within one year of birth.
- The Subscriber is legally obligated to pay the costs of birth.
- The Subscriber has notified us of his or her acceptability to adopt children within 60 days after approval is received or within 60 days after a change in health care coverage.

This coverage is secondary to any coverage for maternity-related expenses that the birth mother may have and Benefits will be coordinated as described in *Section 7: Coordination of Benefits.*

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

25. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force,* including counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include:
  - Screening newborns for hearing problems, thyroid disease, phenylketonuria, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.
  - For children: Counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders; counseling for obesity.
  - Well child visits and immunizations are covered through 47 months as recommended by the *American Academy of Pediatrics.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* Benefits include:
  - Preventive care visits to include preconception and prenatal services.
  - Voluntary family planning and contraceptive services, which include, but are not limited to the following services:
    - Office visits and exams (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
    - Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).
    - Contraceptive device fittings, insertions and removals (e.g. IUDs, diaphragms, cervical caps).
    - Female sterilization methods, including surgical sterilization (tubal ligation) and implantable sterilization (e.g. Essure).
  - Breastfeeding support and counseling, includes lactation support counseling during pregnancy and/or in the post-partum period.
  - Human papillomavirus (HPV) DNA testing for women 30 years and older.
  - Domestic violence screening and counseling.
  - Annual human immunodeficiency virus (HIV) screening and counseling.
  - Annual sexually-transmitted infection counseling.
  - Screening for gestational diabetes for all pregnant women that have not prior history of diabetes.
  - Genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing.
  - Osteoporosis screening.

  Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting us at www.myuhc.com or the telephone number on your ID card.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

Benefits for screening mammography are provided, at a minimum, according to the following guidelines:

- A single baseline mammogram for a woman age 35 through 39.
- A mammogram every year for a woman age 40 and older.
- Non-routine mammograms will be covered more frequently based on the recommendation of the woman's Physician.

- With respect to all at an appropriate age and/or risk status, Benefits include:
  - Counseling and/or screening for: colorectal cancer, elevated cholesterol and lipids; sexually transmitted diseases; human immunodeficiency virus (HIV); depression; high blood pressure; diabetes; PPACA Zero-Cost Share Preventive Care Medications.
  - Screening and counseling for alcohol abuse in a primary care setting; obesity; diet and nutrition.
  - Behavioral counseling to prevent skin cancer for ages 10 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Benefits for PPACA Zero-Cost Share Preventive Care Medications are provided as described under the *Outpatient Prescription Drug Rider.*

You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at **www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm** and the women's preventive services at **www.hrsa.gov/womensguidelines/**. If you do not have internet access, please call us at the telephone number on your ID card.

26. Prosthetic Devices

External prosthetic devices that replace a limb or a body part and are necessary for the alleviation or correction of illness, Injury, congenital defect or alopecia as a result of chemotherapy, radiation therapy, and second or third degree burns. External prosthetic devices are limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras. Benefits for lymphedema stockings are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies.*
- Wigs and hair pieces when you provide a valid prescription verifying diagnosis of alopecia as a result of chemotherapy, radiation therapy, second or third degree burns.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Health Care Service for which Benefits are available under the applicable medical/surgical Covered Health Care Service categories in this *Certificate.*

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except as described in *Section 2: Exclusions and Limitations,* under *Devices, Appliances and Prosthetics.*

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

27. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either of the following:

- Treatment of a medical condition.
- Improvement or restoration of physiologic function.

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. Benefits also include cosmetic surgery for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental Injury. Cosmetic Procedures are covered for congenital defects and birth abnormalities for eligible Dependent children.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures and excluded from coverage. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998,* including breast prostheses (at least two external post-operative breast prostheses) and treatment of complications for all stages of the mastectomy (including lymphedemas), are provided in the same manner and at the same level as those for any other Covered Health Care Service. You can call us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

28. Rehabilitation Services - Outpatient Therapy

For purposes of this Benefit, "rehabilitative services" means Skilled Care services that are part of a prescribed treatment plan to help a person with a disabling condition to regain a skill or function required for functioning for daily living that has been acquired but lost due to illness, injury or disabling condition. Therapies provided for the purpose of general well-being, maintenance/preventive treatment or conditioning in the absence of a disabling condition are not considered rehabilitative services. Short-term outpatient rehabilitation services are limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in your home by a Home Health Agency are provided as described under *Home Health Care.* Rehabilitative services provided in your home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Rehabilitation goals have previously been met.

Benefits are not available for maintenance/preventive treatment.

For outpatient rehabilitative services for speech therapy we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

29. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include:

- Colonoscopy.
- Sigmoidoscopy.
- Diagnostic endoscopy.

Please note that Benefits do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.*

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Benefits that apply to certain preventive screenings are described under *Preventive Care Services.*

30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*

Please note that Benefits are available only if both of the following are true:

- If the first confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective option to an Inpatient Stay in a Hospital.
- You will receive Skilled Care services that are not primarily Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed rehabilitation services.
- Discharge rehabilitation goals have previously been met.

31. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Benefits are available for any service performed in a Hospital's outpatient department or in a freestanding surgical facility, providing such service would have been a Covered Health Care Service if performed as an inpatient service.

Benefits include certain scopic procedures. Examples of surgical scopic procedures include:

- Arthroscopy.
- Laparoscopy.
- Bronchoscopy.
- Hysteroscopy.

Benefits also include vasectomy procedures. (Benefits for female sterilization methods are described under *Preventive Care Services.*)

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

Examples of surgical procedures performed in a Physician's office are mole removal, ear wax removal and cast application.

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.)*
- Medically Necessary implantable devices/prostheses. Implantable devices/prostheses are permanent or temporary internal aids and supports for non-functional body parts. This includes testicular implants following Medically Necessary surgical removal of the testicles. Benefits are also available for repairs, maintenance, or replacement of covered implementable devices/prostheses when Medically Necessary.

32. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of TMJ and associated muscles as a result of an accident; trauma; a congenital defect; a developmental defect; or a pathology. Covered expenses include diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including:

- Clinical exams.
- Oral appliances (orthotic splints).
- Arthrocentesis.
- Trigger-point injections.

Benefits for surgical services include:

- Arthrocentesis.
- Arthroscopy.
- Arthroplasty.
- Arthrotomy.
- Open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

33. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including:

- Dialysis (both hemodialysis and peritoneal dialysis).
- Intravenous chemotherapy or other intravenous infusion therapy.
- Radiation oncology.

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include:

- The facility charge and the charge for related supplies and equipment.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*

34. Transplantation Services

Organ and tissue transplants, including CAR-T cell therapy for malignancies, when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Care Service, and is not an Experimental or Investigational or Unproven Service. Covered Health Care Services also include the costs for the organ procurement.

Examples of transplants for which Benefits are available include:

- Allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, including CAR-T cell therapy for malignancies.
- Heart.
- Heart/lung.
- Lung.
- Kidney.
- Kidney/pancreas.
- Kidney/liver.
- Liver.
- Liver/small intestine.
- Pancreas.
- Small intestine.
- Cornea.

Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Policy, limited to donor.

- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

You can call us at the telephone number on your ID card for information about our specific guidelines regarding Benefits for transplant services.

Benefits for Transplantation Travel Services:

Travel expenses incurred by you in connection with a prior authorized organ and/or tissue transplant are covered subject to the following conditions and limitations:

- Travel expenses are limited to $10,000.
- Benefits for organ transplant travel expenses are not available for cornea transplants.
- Benefits for transportation, lodging and food are available only for you if you are receiving a prior-authorized organ and/or tissue transplant or transplant related services from a Network transplant facility designated by us. Transplant related services include evaluation, candidacy, transplant event, or post-transplant care.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated based on your home address and the transplant facility location. Travel expenses will include charges for:

- Transportation to and from the transplant facility location (including charges for a rental car used during a period of care at the transplant facility).
- Transportation to and from the transplant site in a personal vehicle will be reimbursed per mile (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel) when the transplant facility location is more than 60 miles one way from your home.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

- Lodging while at, or traveling to and from the transplant facility location.
- Food while at, or traveling to and from the transplant facility location.

In addition to the covered travel expenses listed above, Benefits for travel expenses are also available for one companion to accompany you while you are receiving the transplantation services. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. Expenses incurred by your companion will be accumulated toward your $10,000 limit per transplantation service described above.

35. Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury.*

36. Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

37. Virtual Visits

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician, through use of live audio with video technology or audio only outside of a medical facility (for example, from home or from work). Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email or fax, or for telehealth/telemedicine visits that occur within medical facilities *(CMS* defined originating facilities).

Additional Benefits Required By Arizona Law

38. Biofeedback for Pain Management

Benefits are provided for biofeedback when used for pain management.

39. Dental Services - Hospital or Alternate Facility/Anesthesia

Benefits for general anesthesia and associated Hospital or Alternate Facility charges in connection with dental services for oral surgery are available when your underlying medical condition requires general anesthesia to be rendered in a Hospital or Alternate Facility setting. Underlying medical conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia).

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

40. Manipulative Treatment and Chiropractic Care

Benefits are available for Manipulative Treatment when performed by a Physician or licensed chiropractic provider.

Benefits can be denied or shortened when either of the following applies:

- You are not progressing in goal-directed Manipulative Treatment.
- Treatment goals have previously been met.

Benefits are not available for maintenance/preventive Manipulative Treatment.

41. Off-Label Drugs for the Treatment of Cancer

Benefits are available for drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:

- The acceptable standard medical reference compendia are the following:
  - The *American Hospital Formulary Service Drug Information,* a publication of the *American Society of Health System Pharmacists.*
  - The *National Comprehensive Cancer Network Drugs and Biologics Compendium.*
  - *Thomson Micromedex Compendium DRUGDEX.*
  - *Elsevier Gold Standard's Clinical Pharmacology Compendium.*
  - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services.*
- Medical literature may be accepted if all of the following apply:
  - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
  - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
  - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors,* or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).

42. Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are provided when determined to be Medically Necessary.

43. Telemedicine

Benefits are available for health care services received through telemedicine if the health care service would be covered were it provided through in-person consultation between you and a health care provider and provided to you while receiving the Covered Health Care Service in the state of Arizona. We will not limit or deny Covered Health Care Services provided through telemedicine and may apply only the same limits or exclusions on health care services provided through telemedicine that are applicable to an in-person consultation for the same health care service. Health care services appropriately provided through telemedicine are subject to all terms and conditions of the Policy.

Health care services provided through telemedicine or resulting from a telemedicine consultation are subject to all

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

of Arizona state laws and rules that govern prescribing, dispensing and administering prescription pharmaceuticals and devices and shall comply with Arizona license requirements, and any practice guidelines of a national association of medical professionals promoting access to medical care for consumers via telecommunications technology or other qualified medical professional societies to ensure quality of care.

For the purpose of this Benefit:

- "Telemedicine" means the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

Please refer to the Additional Benefits Required By Arizona Law section for additional Covered Health Care Services.

Section 2: Exclusions and Limitations

How Do We Use Headings in this Section?

To help you find exclusions, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in *Section 1: Covered Health Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Health Care Service categories described in *Section 1: Covered Health Care Services,* those limits are stated in the corresponding Covered Health Care Service category in the *Schedule of Benefits.* Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Adventure-based therapy, wilderness therapy, outdoor therapy, or similar programs.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Integrative Health (NCCIH)* of the *National Institutes of Health.* This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Care Services.*

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia).

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

This exclusion does not apply if you have an underlying medical condition that requires general anesthesia to be rendered in a Hospital or Alternate Facility setting as described under *Dental Services - Hospital or Alternate Facility/Anesthesia* in *Section 1: Covered Health Care Services.*

This exclusion does not apply to Covered Dental Services if you are under the age of 19 for which Benefits are provided as described in the *Pediatric Dental Services Rider.*

This exclusion does not apply to dental care (oral exam, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Removal, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*

   This exclusion does not apply to Covered Dental Services if you are under the age of 19 for which Benefits are provided as described in the *Pediatric Dental Services Rider.*
3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Care Services.*
4. Dental braces (orthodontics). This exclusion does not apply to orthodontic services for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Care Services.* This exclusion does not apply to Covered Dental Services if you are under the age of 19 for which Benefits are provided as described in the *Pediatric Dental Services Rider.*
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used as safety items or to help performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies in Section 1: Covered Health Care Services.* This exclusion does not apply to orthotic devices for the treatment of diabetes as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.
4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.

- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

5. Devices and computers to help in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
6. Oral appliances for snoring.
7. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
9. Powered and non-powered exoskeleton devices.

D. Drugs

1. Non-injectable medications given in a Physician's office, except as described in the *Outpatient Prescription Drug Rider.* This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office.
2. Over-the-counter drugs and treatments. This exclusion does not apply to:
   - Over-the-counter aids and/or drugs used for tobacco cessation for which Benefits are available as described in the *Outpatient Prescription Drug Rider.*
   - Aspirin for which Benefits are available as recommended by the *United States Preventive Task Force* as a preventive care service.
   - Counseling and interventions to prevent tobacco use and tobacco-related disease in adults and pregnant women counseling and interventions as described under *Preventive Care Services* in *Section 1: Covered Health Care Services.*
   - Over-the-counter contraceptives for women when prescribed by a licensed health care professional for which Benefits are available as described under the *Outpatient Prescription Drug Rider.*
   - Over-the-counter insulin for the management and treatment of diabetes as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
   - All other *United States Preventive Services Task Force* "A" and "B" recommended over-the-counter medications and supplements when prescribed by a Network provider. You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at **http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations.** If you do not have internet access, please contact us at the telephone number on your ID card.
3. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by us or our designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in *Section 1: Covered Health Care Services.*
4. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

5. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

6. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceuti cal Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutic al Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

7. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

   - Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigati onal or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*

The exclusion will not limit or exclude coverage for any prescription drug approved by the *U.S. Food and Drug Administration (FDA)* prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the *U.S. Food and Drug Administration* for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia.

- The acceptable standard medical reference compendia are the following:
  - The *American Hospital Formulary Service Drug Information,* a publication of the *American Society of Health System Pharmacists.*
  - The *National Comprehensive Cancer Network Drugs and Biologics Compendium.*
  - *Thomson Micromedex Compendium DRUGDEX.*
  - *Elsevier Gold Standard's Clinical Pharmacology Compendium.*
  - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services.*
- Medical literature may be accepted if all of the following apply:
  - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
  - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
  - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors,* or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable

peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of subluxation of the foot.
5. Shoes.
6. Shoe orthotics.
7. Shoe inserts. This exclusion does not apply to preventive foot care if you have diabetes, and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
8. Arch supports. This exclusion does not apply to preventive foot care if you have diabetes, and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*

G. Gender Dysphoria

1. Cosmetic Procedures, including the following:
   - Abdominoplasty.
   - Blepharoplasty.
   - Breast enlargement, including augmentation mammoplasty and breast implants.
   - Body contouring, such as lipoplasty.
   - Brow lift.
   - Calf implants.
   - Cheek, chin, and nose implants.
   - Injection of fillers or neurotoxins.
   - Face lift, forehead lift, or neck tightening.
   - Facial bone remodeling for facial feminizations.
   - Hair removal.
   - Hair transplantation.
   - Lip augmentation.
   - Lip reduction.
   - Liposuction.
   - Mastopexy.
   - Pectoral implants for chest masculinization.

- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

H. Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Compression stockings. This exclusion does not apply to compression garments for treatment of lymphedema.
   - Ace bandages.
   - Gauze and dressings.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices* in *Section 1: Covered Health Care Services.* This exception does not apply to supplies for the administration of medical food products.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Care Services.*
   - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Care Services.*
   - Medical supplies, which may be considered disposable, when obtained from a Network provider for treatment of a specific medical condition and determined to be Medically Necessary.
   - Urinary catheters and related urologic supplies for which Benefits are provided as described under *Urinary Catheters* in *Section 1: Covered Health Care Services.*
2. Tubings and masks except when used with DME as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in *Section 1: Covered Health Care Services.*
3. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes.
4. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

I. Mental Health Care and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations,* the exclusions listed directly below apply to services described under *Mental Health Care and Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Care Services.*

1. Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.*
2. Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Outside of an assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act.*
6. Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
7. Transitional Living services.
8. Non-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including *American Society of Addiction Medicine (ASAM)* criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

J. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional evaluation and counseling services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:
    - Morbid obesity.
    - Diabetes.
    - Cardiovascular disease.
    - Hypertension.
    - Kidney disease.
    - Eating disorders.
    - Gastrointestinal disorders.
    - Food allergies.
    - Hyperlipidemia.
2. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under *Enteral Nutrition* in *Section 1: Covered Health Care Services* and Benefits for Eosinophilic Gastrointestinal Disorder Formula as described under the *Outpatient Prescription Drug Rider.*
3. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. See the Benefits for Eosinophilic Gastrointestinal Disorder Formula described under the *Outpatient Prescription Drug Rider.*

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
    - Air conditioners, air purifiers and filters and dehumidifiers.

- Batteries and battery chargers. This exclusion does not apply to batteries for cochlear implants.
- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
- Exercise equipment.
- Home modifications such as elevators, handrails and ramps.
- Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Mattresses.
- Medical alert systems.
- Motorized beds.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms.* Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Diet counseling for adults with higher risk of chronic disease is covered under *Preventive Care Services* in *Section 1: Covered Health Care Services.*
6. Wigs regardless of the reason for the hair loss, except as provided as described under *Prosthetic Devices* in *Section 1: Covered Health Care Services.*

M. Procedures and Treatments

1. Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, or Congenital Anomaly or other medical or Mental Illness/Substance-Related and Addictive Disorder Services.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or stroke.
7. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback, except as provided under Biofeedback for Pain Management in Section 1: Covered Health Care Services.
9. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to orthognathic surgery for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Care Services.*
10. Non-surgical treatment of obesity.
11. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Care Services.*
12. Helicobacter pylori (H. pylori) serologic testing.
13. Intracellular micronutrient testing.
14. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

N. Providers

1. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or

representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

- Has not been involved in your medical care prior to ordering the service, or
- Is not involved in your medical care after the service is received.

This exclusion does not apply to mammography.

O. Reproduction

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
   - All costs related to reproductive techniques including:
     - Assistive reproductive technology.
     - Artificial insemination.
     - Intrauterine insemination.
     - Obtaining and transferring embryo(s).
   - Health care services including:
     - Inpatient or outpatient prenatal care and/or preventive care.
     - Screenings and/or diagnostic testing.
     - Delivery and post-natal care.

     The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
   - All fees including:
     - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
     - Surrogate insurance premiums.
     - Travel or transportation fees.
3. Costs of donor eggs and donor sperm.
4. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
5. The reversal of voluntary sterilization.
6. In vitro fertilization regardless of the reason for treatment.

P. Services Provided under another Plan

1. Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation, or similar legislation. This exclusion does not apply to Groups that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners and/or partners.
2. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health care services during active military duty, when you are on active duty for more than 30 days.

Q. Transplants

1. Health care services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Care Services.*
2. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health care services for transplants involving animal organs.

R. Travel

1. Health care services provided in a foreign country, unless required as Emergency Health Care Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be reimbursed as determined by us. This exclusion does not apply to the following:
   - Ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Care Services.*
   - Travel expenses for transplantation services for which Benefits are provided as described under *Transplantation Services* in *Section 1: Covered Health Care Services.* Travel and lodging expenses are excluded if you are a donor.

S. Types of Care

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing or inpatient Private Room except when determined Medically Necessary.
4. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Care Services.*
5. Rest cures.
6. Services of personal care aides.
7. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

T. Vision and Hearing

1. Cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to Vision Care Services if you are under the age of 19 for which Benefits are provided as described in the *Pediatric Vision Care Services Rider.* This exclusion does not apply to the first pair of contacts and eyeglasses for treatment of keratoconus or post-cataract surgery.
2. Routine vision exams, including refractive exams to determine the need for vision correction. This exclusion does not apply to Vision Care Services if you are under the age of 19 for which Benefits are provided as described in the *Pediatric Vision Care Services Rider.* This exclusion does not apply to Benefits for screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors are provided under *Preventive Care Services* in *Section 1: Covered Health Care Services* or to routine vision examination services for which Benefits are provided as described in the *Routine Vision Examination Rider*.
3. Implantable lenses used only to fix a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.

6. Bone anchored hearing aids except when either of the following applies:

   - You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.
   - You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid.

   More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy.

   Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

U. All Other Exclusions

1. Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

   - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
   - Medically Necessary.
   - Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits.*
   - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*

2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:

   - Required only for school, sports or camp, career or employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
   - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
   - Required to get or maintain a license of any type.

3. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended.
5. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy.
6. In the event an out-of-Network provider waives, does not pursue, or fails to collect, Co-payments, Co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Co-payments, Co-insurance and/or deductible are waived.
7. Charges in excess of the Allowed Amount or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy.

10. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

11. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service.

    For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for health care services that you receive before your effective date of coverage.

What If You Are Hospitalized When Your Coverage Begins?

We will pay Benefits for Covered Health Care Services when all of the following apply:

- You are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins.
- You receive Covered Health Care Services on or after your first day of coverage related to that Inpatient Stay.
- You receive Covered Health Care Services in accordance with the terms of the Policy.

These Benefits will be paid subject to coordination of benefits with your previous carrier.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as reasonably possible. For plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Care Services from Network providers.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms.*

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms.*

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Except as described below, coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Coverage for a newborn child, adopted child or a child placed for adoption begins on the date of birth, adoption, placement for adoption and will remain in effect for 31 days. If payment of additional Premium is required in order to provide coverage for the child, the Subscriber must notify us of the event and pay any additional required Premium within 31 days of the event in order to continue coverage beyond the initial 31 day period.

Coverage for any other Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Special Enrollment Period Required by Federal Law

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period as required by Federal law.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period or the Eligible Person or Dependent is employed by an employer that offers multiple health benefit plans and the person elected a different plan during Open Enrollment and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including termination of employment, reduction in the number of hours of employment, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.

- The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period, during which the Eligible Person or his or her Dependent may enroll in or change from one qualified health plan (QHP) to another if one of the following is true:

- The Eligible Person or his or her Dependent loses minimum essential coverage:
  - In the case of a QHP decertification, the triggering event is the date of the notice of decertification; or
  - In all other cases, the triggering event is the date the Eligible Person or Dependent loses eligibility for minimum essential coverage;
- The Eligible Person gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care;
- The Eligible Person, or his or her Dependent, which was not previously a citizen, national, or lawfully present individual gains such status;
- The Eligible Person's or his or her Dependent's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the *Exchange or HHS,* or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- The Eligible Person or his or her Dependent adequately demonstrates that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- The Eligible Person or his or her Dependent are newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.
  - The Eligible Person is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;
  - The Eligible Person's Dependent enrolled in the same QHP is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions; or
  - The Eligible Person or his or her Dependent who is enrolled in an eligible employer-sponsore d plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan, including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage. The exchange must permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her coverage in an eligible employer-sponsored plan;
- The Eligible Person, or his or her Dependent, gains access to new QHPs as a result of a permanent move;
- The Eligible Person who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month;

The Eligible Person, or his or her Dependent, demonstrates, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy. We will provide at least sixty (60) days advance written notice to the Subscriber that coverage will terminate or nonrenew on the date we identify in the notice.

Your right to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that if you are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. We are responsible for notifying you that your coverage has ended when it ends at the request of the Group, for the Group's failure to pay Premium, or for fraud on the part of the Group. We will provide at least sixty (60) days advance written notice to the Subscriber if the Policy is terminated or nonrenewed on the date we identify in the notice.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the last day of the calendar month in which we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's Application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least sixty (60) days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because the Group committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an

intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Coverage for a Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental, or physical disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that exam.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage when you are Totally Disabled on the date the entire Policy ends will not end automatically. We will extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The date the Total Disability ends.
- Twelve months from the date your coverage would have ended when the entire Policy ends.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with Arizona law.

Continuation coverage under COBRA (the federal Consolidated *Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of COBRA. Contact your plan administrator to find out if your Group is subject to the provisions of COBRA.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Conversion

If your coverage under the Policy ends for one of the reasons described below, you may apply for conversion coverage under an individual conversion policy. The right to apply for conversion coverage applies to you if you are a Subscriber or an Enrolled Dependent.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

Application and payment of the first Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Coverage provided by the conversion policy will provide Benefits most similar to the coverage included under this Policy.

Section 5: How to File a Claim

How Are Covered Health Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact us. However, you are required to meet any applicable deductible and to pay any required Co-payments and Co-insurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within two years of the date of service, Benefits for that health care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The telephone number for *Customer Care* stated on the back of your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum RX

PO Box 29077

Hot Springs, AR 71903

Payment of Benefits

We will pay Benefits within 30 days after we receive your request for payment that includes all required information.

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network provider with our consent, and the out-of-Network provider submits a claim for payment, you and the out-of-Network provider represent and warrant the following:

- The Covered Health Care Services were actually provided.
- The Covered Health Care Services were Medically Necessary.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

Appeals and Grievance Process

You may participate in UnitedHealthcare's appeals and grievance process. Our appeals and grievance process is explained in detail in the UnitedHealthcare *Health Care Insurer Appeals Process Information Packet.* The *Health Care Insurer Appeals Process Information Packet* will be provided to you as follows:

- **Upon Initial Enrollment:** A copy of the *Health Care Insurer Appeals Process Information Packet* will be attached to your *Certificate of Coverage* upon initial enrollment.
- **When You Commence an Appeal:** The *Health Care Insurer Appeals Process Information Packet* will be provided to you within 5 business days after we receive your request for an appeal.
- **When Your Health Plan Coverage is Renewed:** When your coverage under the Policy is renewed, we will send you a separate statement with your *Certificate of Coverage* to remind you that you can request to receive another copy of the *Health Care Insurer Appeals Process Information Packet* by calling the telephone number on the back of your ID card.

Upon Your Request or Your Treating Provider's Request: You or your treating provider may obtain a copy of the *Health Care Insurer Appeals Process Information Packet* at any time by calling the telephone number on the back of your ID card or our Appeals Department at 1-800-442-4199.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is based on Arizona regulations.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one benefit Plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

A. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

   1. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group contracts; and Medicare or other governmental benefits, as permitted by law.

   2. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies, Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

B. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Care Coverage Plan's benefits.

C. "Allowable Expense" means any necessary, reasonable and customary item of expense at least a portion of which is covered under one or more of the Coverage Plans covering the person for whom claim is made or service is provided. When a Coverage Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense of service that is not covered by any of the Coverage Plans is not an Allowable Expense.

   A Coverage Plan that takes Medicare or similar government benefits into consideration when determining the application of the coordination of benefits provision does not expand the definition of an allowable expense.

D. "Claim Determination Period" means a calendar year. However, it does not include any part of a year in which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

E. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

What Are the Rules for Determining the Order of Benefit Determination Payments?

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that uses an order of benefit determination provision which is inconsistent with this regulation is called a non-complying plan. A Coverage Plan that complies with this provision, called a complying plan, may coordinate its benefits with a non-complying plan. If the complying plan is the primary Coverage Plan, it will pay or provide its benefits on a primary basis. If the complying plan is the Secondary Coverage Plan, it will pay or provide its benefits first as the Secondary Coverage Plan.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describe which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a) The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier by month or day of the year if:

(1) The parents are married;

(2) The parents are not separated (whether or not they ever have been married); or

(3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses of health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rules applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

(1) The Coverage Plan of the custodial parent

(2) The Coverage Plan of the spouse of the custodial parent

(3) The Coverage Plan of the noncustodial parent

d) If one of the Coverage Plans is used outside the state of Arizona and it determines the order of benefits based upon the gender of a parent, and if, as a result, the plans do not agree on the order of benefits, the Coverage Plan with the gender rule shall determine the order of benefits.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee.

   If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).

4. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

Effects of Benefits on this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Coverage Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Coverage Plan. The Secondary Coverage Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Coverage Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Coverage Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. If you have other coverage, from any other source, which may be primarily responsible for benefits, you agree to submit claims to that coverage before submitting claims to the Plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. Except in cases of fraud, we will not adjust or request adjustment of the payment of a claim more than one year after we have paid the claim.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the health care that you may receive. The Policy pays for Covered Health Care Services, which are more fully described in this *Certificate.*
- The Policy may not pay for all treatments you or your Physician may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

We have agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to Covered Persons.

We do not provide health care services or supplies, or practice medicine. We arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. We are not responsible for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor.*

What Is Your Relationship with Providers and Groups?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider.
- Paying, directly to your provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any deductible and any amount that exceeds the Allowed Amount.
- Paying, directly to your provider, the cost of any non-Covered Health Care Service.

- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Notice

We provide written notice regarding administration of the Policy to an authorized representative of the Group and to all affected Subscribers.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Do We Pay Incentives to Providers?

We pay Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be

required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in the applicable Benefit category in your *Schedule of Benefits.*

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also call us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Physician. Contact us at www.myuhc.com or the telephone number on your ID card if you have any questions.

Do We Receive Rebates and Other Payments?

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. As determined by us, we pass a portion of these rebates on to you. When rebates may be passed onto you, they are taken into account in determining your Co-payment and/or Co-insurance.

Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate,* the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy. We will provide the Group and all affected Subscribers with 60 days prior notice of changes to the Policy that would be effective on the anniversary date of the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices.*

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices.*

For complete listings of your medical records or billing statements you may contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or Dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy.

Important Notice - Third Party Payers

When there is a third party source of payment such as a liability insurer, a government payer, or any uninsured and/or underinsured motorist coverage, Network providers may be entitled to collect from the third parties. They may be entitled to collect any difference between the Allowed Amount that we pay and the Network providers' customary charges, pursuant to A.R.S. 33-931. Arizona law prohibits providers from charging you more than the Co-payment and any deductible you are required to pay as described in this *Certificate of Coverage.*

Is There a Limitation of Action?

After you have properly submitted a request for reimbursement, as described in *Section 5: How to File a Claim,* you must wait 60 days before bringing legal action against us. In the interest of saving time and money, you are encouraged to first complete all steps in the appeal process described in *Section 6: Questions, Complaints and Appeals.*

If you want to bring a legal action against us you must do so within three years from the applicable date specified below or you lose any rights to bring such an action against us:

- The expiration date for the time period in which you must submit a request for reimbursement.
- The date we notified you of our final decision on your appeal.

What Is the Entire Policy?

The Policy, this *Certificate,* the *Schedule of Benefits,* the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Allowed Amounts - for Covered Health Care Services, incurred while the Policy is in effect, Allowed Amounts are determined by us as shown in the *Schedule of Benefits.*

Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines. We develop these guidelines, as we determine, after review of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Procedural Terminology (CPT),* a publication of the *American Medical Association,* and/or the *Centers for Medicare and Medicaid Services (CMS).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Alternate Facility - a health care facility that is not a Hospital. It provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Health Care Services per year before we will begin paying for Benefits. It does not include any amount that exceeds Allowed Amounts. The *Schedule of Benefits* will tell you if your plan is subject to payment of an Annual Deductible and how it applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Care Services that are available under the Policy.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Co-insurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Health Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

Please note that for Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Co-payment.
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.

- Described as a Covered Health Care Service in this *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits.*
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations.*

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non health-related services such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins,* the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26 . The term "child is described above.
- A child is no longer eligible as a Dependent on the last day of the month following the date the child reaches age 26 except as provided in *Section 4: When Coverage Ends under Coverage for a Disabled Dependent Child.*

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26 .

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Designated Network Benefits - the description of how Benefits are paid for certain Covered Health Care Services provided by a provider or facility that has been identified as a Designated Provider. The *Schedule of Benefits* will tell you if your plan offers Designated Network Benefits and how they apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with us, or with an organization contracting on our behalf, to provide Covered Health Care Service for the treatment of specific diseases or conditions; or
- We have identified through our designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting us at www.myuhc.c om or the telephone number on your ID card.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Dispute - it includes questions of coverage, payment, and other issues strictly between us and members, but does not include any process with a state right to an appeal or judicial review, including, but not limited to external independent review or out-of-network claim Dispute resolution.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Be mentally able to consent to contract.
- They must be financially interdependent and they have provided documents to support at least two of the following conditions of such financial interdependence:
    - They have a single dedicated relationship of at least 6 - 18 months.
    - They have joint ownership of a residence.
    - They have at least two of the following:
        - A joint ownership of an automobile.
        - A joint checking, bank or investment account.
        - A joint credit account.
        - A lease for a residence identifying both partners as tenants.
        - A will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

- Is ordered by a Physician in accordance with accepted medical practice;
- Is able to resist wear and/or decay and to withstand repeated usage;
- Appropriate for use in the home; and
- Is not useful in the absence of an illness or Injury.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Emergency - a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- For a pregnant woman, the health of the woman or her unborn child.

Emergency Health Care Services - with respect to an Emergency:

- A medical screening exam (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical exam and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Care Services do not require prior authorization.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Care Services.*
- We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - You are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Care Services:* and
  - You have a Sickness or condition that is likely to cause death within one year of the request for treatment.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

- This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
  - The acceptable standard medical reference compendia are the following:
    - The *American Hospital Formulary Service Drug Information,* a publication of the *American Society of Health System Pharmacists.*
    - The *National Comprehensive Cancer Network Drugs and Biologics Compendium.*
    - *Thomson Micromedex Compendium DRUGDEX.*
    - *Elsevier Gold Standard's Clinical Pharmacology Compendium.*
    - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services.*
  - Medical literature may be accepted if all of the following apply:
    - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

- ♦ No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
- ♦ The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors,* or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Care Services for Genetic Testing require Genetic Counseling.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient health care services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy), as authorized by law:

- A long term acute rehabilitation center,
- A Hospital, or
- A special unit of a Hospital designated as an Inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA).*

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Medically Necessary - health care services that are all of the following as determined by us or our designee:

- In accordance with *Generally Accepted Standards of Medical Practice.*
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act,* as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Care Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of

the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Health Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The *Schedule of Benefits* will tell you if your plan offers Network Benefits and how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date as determined by us or our designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment Period - An annual period, usually occurring shortly before the beginning of a new plan year, during which Eligible Persons can enroll for benefits and change their elections under the Group's Policy. The Open Enrollment Period is effective based on the date agreed upon between the Group and us.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of-Network providers. The *Schedule of Benefits* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you pay every year. The *Schedule of Benefits* will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program. The program may be freestanding or Hospital-based and provides services for at least 20 hours per week.

Per Occurrence Deductible - the portion of the Allowed Amount (stated as a set dollar amount) that you must pay for certain Covered Health Care Services prior to, and in addition to, any Annual Deductible before we begin paying Benefits for those Covered Health Care Services.

When a plan has a Per Occurrence Deductible, you are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Allowed Amount.

The *Schedule of Benefits* will tell you if your plan is subject to payment of a Per Occurrence Deductible and how the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law to provide services that are within the lawful scope of practice of Physician (as defined by Arizona law).

Please Note: Any podiatrist, dentist, psychologist, psychiatrist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy.*
- *Certificate.*
- *Schedule of Benefits.*
- Group *Application.*
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Care Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - services that are provided from a registered nurse (RN) or a licensed practical nurse (LPN), in accordance with a Physician's care plan.

Private Room - private room accommodations means a Hospital room containing one bed.

Psychiatric Service - psychotherapy and other accepted forms of evaluation, diagnosis, or treatment of mental or emotional disorders. This includes individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations; and any other forms of psychotherapeutic treatment as determined to be Medically Necessary.

Residential Treatment - treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hour per day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Care Services not described in this *Certificate.* Covered Health Care Services provided by a Rider may be subject to payment of additional Premiums. (Note that Benefits for Outpatient Prescription Drugs, Pediatric Vision Care Services and Pediatric Dental Services, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy.) Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Care Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi-private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association.* The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders Services provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria, and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide stable and safe housing and the opportunity to learn how to manage activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the

medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health care services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health.*
- We may, as we determine, consider an otherwise Unproven Service to be a Covered Health Care Service for a Covered Person with a Sickness or Injury that is not life threatening. For that to occur, all of the following conditions must be met:
    - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
    - The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and the state of Arizona do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and the state of Arizona to conclude that the service is promising but unproven, and
    - The service must be available from a Network Physician and/or a Network facility.
    - The decision about whether such a service can be deemed a Covered Health Care Service is solely at UnitedHealthcare and the state of Arizona's discretion.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Gold

UHC Choice Plus Gold 1000-1

How Do You Access Benefits?

You can choose to receive Designated Network Benefits, Network Benefits or Out-of-Network Benefits.

Designated Network Benefits apply to Covered Health Care Services that are provided by a provider or facility that has been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Care Services as shown in the *Schedule of Benefits* table below.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Network Benefits.

Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits.* **As a result, you will be responsible for the difference between the amount billed by the out-of-Network provider and the amount we determine to be the Allowed Amount for reimbursement. The payments you make to out-of-Network providers for charges above the Allowed Amount do not apply towards any applicable Out-of-Pocket Limit.**

Covered Health Care Services that are provided at a Network facility by an out-of-Network facility based Physician, when not Emergency Health Care Services, will be reimbursed as set forth under *Allowed Amounts* as described at the end of this *Schedule of Benefits.* **As a result, you will be responsible for the difference between the amount billed by the out-of-Network facility based Physician and the amount we determine to be the Allowed Amount for reimbursement. The payments you make to out-of-Network facility based Physicians for charges above the Allowed Amount do not apply towards any applicable Out-of-Pocket Limit.**

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits.*

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Group, this *Schedule of Benefits* will control.

Does Prior Authorization Apply?

We require prior authorization for certain Covered Health Care Services. Network providers are responsible for obtaining prior authorization before they provide these services to you.

We recommend that you confirm with us that all Covered Health Care Services have been prior authorized as required. Before receiving these services from a Network provider, you may want to call us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior

authorization. Network facilities and Network providers cannot bill you for services they do not prior authorize as required. You can call us at the telephone number on your ID card.

When you choose to receive certain Covered Health Care Services from out-of-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit you to a Network facility or to an out-of-Network facility or refers you to other Network or out-of-Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization. Services for which you are required to obtain prior authorization are shown in the *Schedule of Benefits* table within each Covered Health Care Service category.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to find out how far in advance you must obtain prior authorization.

For Covered Health Care Services that do not require you to obtain prior authorization, when you choose to receive services from out-of-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Care Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Care Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Care Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those received, our final coverage determination will be changed to account for those differences, and we will only pay Benefits based on the services delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Care Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to put in place the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits.* You are not required to obtain authorization before receiving Covered Health Care Services.

What Will You Pay for Covered Health Care Services?

Benefits for Covered Health Care Services are described in the tables below.

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Limits are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Lifetime limits on the dollar amount of essential benefits available to you under the terms of the Policy are not permitted. There are no lifetime limits on any of the Benefit categories included in this *Schedule of Benefits.*

Payment Term And Description	**Amounts**
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Benefits for outpatient prescription drugs on the List of Preventive Medications are not subject to payment of the Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Annual Deductible does not include any applicable Per Occurrence Deductible.	***Network*** $1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family. ***Out-of-Network*** $10,000 per Covered Person, not to exceed $20,000 for all Covered Persons in a family.
Per Occurrence Deductible	
The amount stated as a set dollar amount that you must pay for certain Covered Health Care Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Care Services. You are responsible for paying the lesser of the following: • The applicable Per Occurrence Deductible. • The Allowed Amount.	When a Per Occurrence Deductible applies, it is listed below under each Covered Health Care Service category.

Payment Term And Description	Amounts
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Co-payments and Co-insurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. The Out-of-Pocket Limit for Designated Network and Network Benefits includes the amount you pay for both Network and Out-of-Network Benefits for outpatient prescription drug products provided under the *Outpatient Prescription Drug Rider, Pediatric Dental Services Rider* and *Pediatric Vision Care Services Rider.* Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • The amount you are required to pay if you do not obtain prior authorization as required. • Charges that exceed Allowed Amounts.	***Network*** $8,150 per Covered Person, not to exceed $16,300 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible. ***Out-of-Network*** $20,000 per Covered Person, not to exceed $40,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible. The Out-of-Pocket Limit includes the Per Occurrence Deductible.
Co-payment	
Co-payment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Co-payments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Co-payment. • The Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Co-insurance	
Co-insurance is the amount you pay (calculated as a percentage of the Allowed Amount) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
1. Ambulance Services			
Prior Authorization Requirement In most cases, we will initiate and direct non-Emergency ambulance transportation. For Out-of-Network Benefits, if you are requesting non-Emergency air ambulance services (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency air ambulance transport), you must obtain authorization as soon as possible before transport. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Emergency Ambulance Ground, water or air ambulance	***Network*** *Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
	Water Ambulance 20%	Yes	Yes
	Out-of-Network Same as Network	Same as Network	Same as Network

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Non-Emergency Ambulance Ground, water or air ambulance	***Network*** *Ground Ambulance* 20%	Yes	Yes
	Air Ambulance 20%	Yes	Yes
	Water Ambulance 20%	Yes	Yes
	Out-of-Network *Ground Ambulance* 50%	Yes	Yes
	Air Ambulance 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Water Ambulance 50%	Yes	Yes
2. Cellular and Gene Therapy			

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits*.
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits*.

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
3. Clinical Trials			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; and Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
4. Congenital Heart Disease (CHD) Surgeries			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	***Network*** Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*		
	Out-of-Network Benefits will be the same as stated under *Hospital - Inpatient Stay* in this *Schedule of Benefits.*		
5. Dental Services - Accident Only			
	Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Same as Network	Same as Network	Same as Network
6. Diabetes Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Rider.*		
7. Durable Medical Equipment (DME), Orthotics and Supplies			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Compression garments for treatment of lymphedema are limited to one set upon diagnosis. Benefits are limited to four replacements per Policy year when determined Medically Necessary and the compression garment cannot be repaired or when required due to a change in your physical condition. To receive Network Benefits, you must purchase, rent	***Network*** 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
or obtain the DME or orthotic from the vendor we identify or purchase it directly from the prescribing Network Physician.			
	Out-of-Network 50%	Yes	Yes
8. Emergency Health Care Services - Outpatient			
Note: If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Care Service. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Co-payment, Co-insurance and/or deductible. Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.* **As a result, you will be responsible for the difference between the amount**	***Network*** 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
billed by the out-of-Network provider and the amount we determine to be the Allowed Amount for reimbursement.			
	Out-of-Network Same as Network	Same as Network	Same as Network
9. Enteral Nutrition			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
10. Gender Dysphoria			
Prior Authorization Requirement for Surgical Treatment You must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.** **Prior Authorization Requirement for Non-Surgical Treatment** Depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices;* and/or *Reconstructive Procedures* in this Schedule of Benefits and in the *Outpatient Prescription Drug Rider*.		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Durable Medical Equipment (DME),*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Orthotics and Supplies, Hospital - Inpatient Stay; Lab, X-Ray and Diagnostic - Outpatient; Major Diagnostic and Imaging - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Surgery - Outpatient; Prosthetic Devices; and/or *Reconstructive Procedures* in this Schedule of Benefits and in the *Outpatient Prescription Drug Rider*.		
11. Habilitative Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are not subject to an annual limit.	***Network*** *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services* in this *Schedule of Benefits*.		
Outpatient therapies are limited per year as follows: • 60 visits for any combination of physical therapy, occupational therapy and/or speech therapy.	*Outpatient* $60 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
These visit limits do not apply if the primary diagnosis code for the outpatient habilitative service being provided is one for a covered Mental Health Care Service or covered Substance-Related and Addictive Disorders Service.			
	Out-of-Network *Inpatient* Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services* in this *Schedule of Benefits.*		
	Outpatient 50%	Yes	Yes
12. Hearing Aids			
Benefits are limited to a single purchase per hearing impaired ear every year. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
13. Home Health Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Limited to 60 visits per year. One visit equals up to four hours of skilled care services. Home Health Agency services that are provided in lieu of an Inpatient Stay are not subject to this limit. This visit limit does not include any service which is billed only for the administration of intravenous infusion. To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
14. Hospice Care			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
15. Hospital - Inpatient Stay			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
16. Lab, X-Ray and Diagnostic - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
Lab Testing - Outpatient	***Designated Network*** None	Yes	No
	Network 20% at a freestanding lab or in a Physician's office	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	20% at a Hospital-based lab	Yes	Yes
	Out-of-Network 50%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	***Network*** 20% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	20% at an outpatient Hospital-based diagnostic center	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
17. Major Diagnostic and Imaging - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 20% at a freestanding diagnostic center or in a Physician's office	Yes	Yes
	20% at an outpatient Hospital-based diagnostic center	Yes	Yes, after the Per Occurrence Deductible of $350 per service is satisfied
	Out-of-Network 50% at a freestanding diagnostic	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	center or in a Physician's office		
	50% at an outpatient Hospital-based diagnostic center	Yes	Yes, after the Per Occurrence Deductible of $350 per service is satisfied
18. Mental Health Care and Substance-Related and Addictive Disorders Services			

Prior Authorization Requirement

For Out-of-Network Benefits for a scheduled admission for Mental Health Care and Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Out-of-Network Benefits, you must obtain prior authorization before the following services are received: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA).*

If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

Note: Mental Health Care Services and Substance-Related and Addictive Disorder Services received from a Primary Care Physician are subject to the *Physician's Office Services - Sickness and Injury*	***Network*** *Inpatient* 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
cost share as noted in the *Schedule of Benefits* and not the *Mental Health Care and Substance-Related and Addictive Disorders Services* cost share.			
	Outpatient $30 per visit	Yes	No
	20% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes
	Out-of-Network *Inpatient* 50%	Yes	Yes
	Outpatient 50%	Yes	Yes
	50% for Partial Hospitalization/ Intensive Outpatient Treatment	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
19. Obesity - Weight Loss Surgery			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity - weight loss surgery arises. If you do not obtain prior authorizatio n as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay. **It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.**			
For Designated Network Benefits, obesity surgery must be received at a Designated Provider.	***Designated Network*** 30%	Yes	Yes
Network Benefits include services provided at a Network facility that is not a Designated Provider.	***Network*** 50%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
20. Ostomy Supplies			
	Network 20%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
21. Pharmaceutical Products - Outpatient			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
22. Physician Fees for Surgical and Medical Services			
Covered Health Care Services provided by an out-of-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.* **As a result, you will be responsible to the out-of-Network facility based Physician for any amount billed that is greater than the amount we determine to be the Allowed Amount. In order to obtain the highest level of Benefits, you**	***Designated Network*** 20% for Covered Health Care Services from a Primary Care Physician	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
should confirm the Network status of these providers prior to obtaining Covered Health Care Services.			
	20% for Covered Health Care Services from a Specialist	Yes	Yes
	Network 20% for Covered Health Care Services from a Primary Care Physician	Yes	Yes
	20% for Covered Health Care Services from a Specialist	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
23. Physician's Office Services - Sickness and Injury			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*	***Designated Network*** $30 per visit for a Primary Care Physician office visit or $30 per visit for a Specialist office visit	Yes	No
	Network $30 per visit for a Primary Care Physician office visit or $60 per visit for a Specialist office visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
24. Pregnancy - Maternity Services			

Prior Authorization Requirement

For Out-of-Network Benefits, you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.

The coverage for birth costs for an adopted child under this Policy is secondary to any coverage for maternity-related expenses that the birth mother may have and Benefits will be coordinated as described in *Section 7: Coordination of Benefits.*	***Network*** Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services;* and *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
	Out-of-Network Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics -*

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Outpatient; Physician Fees for Surgical and Medical Services; and *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits.*		
25. Preventive Care Services			
Physician office services	***Network*** None	Yes	No
	Out-of-Network 50%	Yes	Yes
Lab, X-ray or other preventive tests	***Network*** None	Yes	No
	Out-of-Network 50%	Yes	Yes
Breast pumps	***Network*** None	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network 50%	Yes	Yes
26. Prosthetic Devices			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device. If you do not obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.			
Wigs and hair pieces for a diagnosis of alopecia as a result of chemotherapy, radiation therapy, or second or third degree burns are limited to one wig or hair piece per year.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
27. Reconstructive Procedures			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital -Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury* and *Prosthetic Devices* in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital -Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician Office Services - Sickness and Injury* and *Prosthetic Devices* in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
28. Rehabilitation Services - Outpatient Therapy			
Limited per year as follows: • Any combination of physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy and/or cardiac rehabilitation therapy are limited to 60 visits per year. Manipulative Treatment is covered under the *Manipulative Treatment and Chiropractic Care* Benefit category in this *Schedule of Benefits.*	***Network*** *Any combination of Manipulative Treatment and chiropractic care and physical therapy for new low back pain* None for the first 3 visits in a year; $60 per visit for all other visits in that year *All other therapies* $60 per visit	Yes Yes	No No
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
29. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 20% at a freestanding center or in a Physician's office	Yes	Yes
	20% at an outpatient Hospital-based center	Yes	Yes
	Out-of-Network 50% at a freestanding center or in a Physician's office	Yes	Yes
	50% at an outpatient Hospital-based center	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement For Out-of-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
Limited to: • 90 days per year in a Skilled Nursing Facility. • Covered Health Care Services in an Inpatient Rehabilitation Facility are not subject to an annual limit.	***Network*** 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
31. Surgery - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 20% at an ambulatory surgical center or in a Physician's office	Yes	Yes
	20% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $350 per date of service is satisfied
	Out-of-Network 50% at an ambulatory surgical center	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.

Covered Health Care Service	What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.	Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Does the Annual Deductible Apply?
	or in a Physician's office		
	50% at an outpatient Hospital-based surgical center	Yes	Yes, after the Per Occurrence Deductible of $350 per date of service is satisfied
32. Temporomandibular Joint (TMJ) Services			

Prior Authorization Requirement

For Out-of-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.

In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.

	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury and Surgery - Outpatient* in this *Schedule of Benefits.*

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury and Surgery - Outpatient* in this *Schedule of Benefits.*		
33. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
34. Transplantation Services			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits, you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, transplantation services must be received from a Designated Provider. We do not require that cornea transplants be received from a Designated Provider in order for you to receive Network Benefits. Travel and lodging expenses are limited to $10,000. Travel and lodging expenses are not covered if you are the donor.	***Network*** Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury and Surgery - Outpatient* in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury and Surgery - Outpatient* in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
35. Urgent Care Center Services			
Co-payment/Co-insurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient.* • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient.* • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.* • Outpatient surgery procedures described under *Surgery - Outpatient.* • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient.*	***Network*** $50 per visit	Yes	No
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
36. Urinary Catheters			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
37. Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at www.myuhc.com or the telephone number on your ID card.	***Network*** None	Yes	No
	Out-of-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
Additional Benefits Required By Arizona Law			
38. Biofeedback for Pain Management			
Prior Authorization Requirement Depending upon where the Covered Health Care Service is provided, prior authorization requirements will be the same as those stated under each Covered Health Care Service category in the Schedule of Benefits.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Emergency Health Care Services - Outpatient; Habilitative Services; Home Health Care; Hospice Care; Hospital - Inpatient Stay; Manipulative Treatment and Chiropractic Care; Mental Health Care and Substance-Related and Addictive Disorders Services; Physician's Office Services - Sickness and Injury; Rehabilitation Services - Outpatient Therapy; Skilled Nursing Facility/Inpatient Rehabilitation Facility Services and Urgent Care Services* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Emergency Health Care Services - Outpatient; Habilitative Services; Home Health Care; Hospice Care; Hospital - Inpatient Stay; Manipulative Treatment and Chiropractic Care; Mental Health Care and Substance-Related and Addictive Disorders Services; Physician's Office Services - Sickness and*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Injury; Rehabilitation Services - Outpatient Therapy; Skilled Nursing Facility/Inpatient Rehabilitation Facility Services and Urgent Care Services in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits.*		
39. Dental Services - Hospital or Alternative Facility/Anesthesia			
Prior Authorization Requirement For Network and Out-of-Network Benefits, you must obtain prior authorization five business days before admission or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount.			
	Network 20%	Yes	Yes
	Out-of-Network 50%	Yes	Yes
40. Manipulative Treatment and Chiropractic Care			
Physical therapy is covered under the *Rehabilitation Services - Outpatient Therapy* Benefit category in this *Schedule of Benefits.*	***Network*** *Any combination of Manipulative Treatment and*	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	chiropractic care and physical therapy for new low back pain None for the first 3 visits in a year; $60 per visit for all other visits in that year		
	Out-of-Network 50%	Yes	Yes
41. Off-Label Drugs for the Treatment of Cancer			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Pharmaceutical Products - Outpatient and Physician Office Services - Sickness and Injury* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits*.		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Pharmaceutical Products - Outpatient and*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
	Physician Office Services - Sickness and Injury in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits*.		
42. Orthognathic Surgery			
Prior Authorization Requirement For Out-of-Network Benefits, you must obtain prior authorization five business days before orthognathic surgery is performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, the amount you are required to pay will be increased to 50% of the Allowed Amount. In addition, for Out-of-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Major Diagnostic and Imaging - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Reconstructive Procedures and Surgery - Outpatient* in this *Schedule of Benefits.*		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Hospital - Inpatient Stay; Lab, X-Ray and Diagnostics - Outpatient; Major Diagnostic and Imaging - Outpatient; Physician Fees for Surgical and Medical Services; Physician's Office Services - Sickness and Injury; Reconstructive Procedures and Surgery - Outpatient* in this *Schedule of Benefits.*		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.			
Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts. The *Allowed Amounts* provision near the end of this *Schedule of Benefits* will tell you when you are responsible for amounts that exceed the Allowed Amount.			
Covered Health Care Service	**What Is the Co-payment or Co-insurance You Pay? This May Include a Co-payment, Co-insurance or Both.**	**Does the Amount You Pay Apply to the Out-of-Pocket Limit?**	**Does the Annual Deductible Apply?**
43. Telemedicine			
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Lab, X-Ray and Diagnostics - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient* and *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits*.		
	Out-of-Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under *Lab, X-Ray and Diagnostics - Outpatient; Mental Health Care and Substance-Related and Addictive Disorders Services; Pharmaceutical Products - Outpatient;* and *Physician's Office Services - Sickness and Injury* in this *Schedule of Benefits* or as described under the *Outpatient Prescription Drug Schedule of Benefits*.		

Allowed Amounts

Allowed Amounts are the amount we determine that we will pay for Benefits. For Designated Network Benefits and Network Benefits for Covered Health Care Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Covered Health Care Services provided by an out-of-Network provider (other than services otherwise arranged by us), you will be responsible to the out-of-Network provider for any amount billed that is greater than the amount we determine to be an Allowed Amount as described below. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider

bills you and the amount we will pay for Allowed Amounts. Allowed Amounts are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate.*

For Designated Network Benefits and Network Benefits, Allowed Amounts are based on the following:

- When Covered Health Care Services are received from a Designated Network and Designated Network and Network provider, Allowed Amounts are our contracted fee(s) with that provider.
- When Covered Health Care Services are received from an out-of-Network provider as arranged by us, Allowed Amounts are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Co-insurance, Co-payment or any deductible . We will not pay excessive charges or amounts you are not legally obligated to pay.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from an out-of-Network provider, Allowed Amounts are determined, based on:
  - Negotiated rates agreed to by the out-of-Network provider and either us or one of our vendors, affiliates or subcontractors.
  - If rates have not been negotiated, then one of the following amounts:
    - Allowed Amounts are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
      - 50% of *CMS* for the same or similar freestanding laboratory service.
      - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
      - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
      - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book),* or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
      - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
      - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

    We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

    IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

For Covered Health Care Services received at a Network facility on a non-Emergency basis from an out-of-Network facility based Physician, the Allowed Amount is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic

market. In some situations we will use a different percentage of the *CMS* rate to make them more consistent with market reimbursement norms. If we cannot determine a *CMS* rate, we will make a best equivalent estimate or allow 50% of billed charges.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book),* or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

IMPORTANT NOTICE: Out-of-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Allowed Amount described here.

For Emergency Health Care Services provided by an out-of-Network provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- The amount that would be paid under Medicare (*part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.*) for the same service.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group.* Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS,* and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book),* or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 20% of the provider's billed charge.

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to choose your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of

providers is available by contacting us at www.myuhc.com or the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment using an out-of-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help to find out if you are eligible for transition of care Benefits, please call the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with us to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for help.

Designated Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Provider chosen by us. If you require certain complex Covered Health Care Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Care Services from a Designated Provider, we may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Care Services for that condition are provided by or arranged by the Designated Provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify us in advance, and if you receive services from an out-of-Network facility (regardless of whether it is a Designated Provider) or other out-of-Network provider, Network Benefits will not be paid. Out-of-Network Benefits may be available if the special needs services you receive are Covered Health Care Services for which Benefits are provided under the Policy.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services. You may designate a Network pediatrician for an Enrolled Dependent child. For obstetrical or gynecological care, you may seek care directly from any Network obstetrician or gynecologist.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Co-payments or Co-insurance you must meet or pay for when receiving these services.

Real Appeal

Real Appeal provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 13 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Care Services will be individualized and may include the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Care Services, you may contact us through www.realappeal.com, https://member.realappeal.com or at the number shown on your ID card.

UnitedHealthcare Insurance Company

William J Golden, President

Routine Vision Examination Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

This Rider to the Policy is issued to the Group and provides Benefits for routine vision exams, as described below for Covered Persons over the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

UnitedHealthcare Insurance Company

William J Golden, President

Section 1: Benefits for Routine Vision Examinations

Benefits are available for Vision Care Services from a Spectera Eyecare Networks Network or out-of-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek payment from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Routine Vision Examinations.* Reimbursement will be limited to the amounts stated below.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits.*

Annual Deductible

Benefits for Vision Care Services provided under this Rider are subject to any Annual Deductible stated in the *Schedule of Benefits.* Any amount you pay in Co-payments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the *Schedule of Benefits.*

What Are the Benefit Descriptions?

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-insurance stated below.

Routine Vision Examination

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for the exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.

- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the internal eye.
- Visual Field testing.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Routine Vision Exam or Refraction only in lieu of a complete exam.	Once per year	None	50% of the billed charge.

Section 2: Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Routine Vision Examinations,* Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Certificate.*

Section 3: Claims for Routine Vision Examinations

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek payment from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Routine Vision Examinations

To file a claim for reimbursement for Vision Care Services rendered by an out-of-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or an out-of-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate:*

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under this Rider.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service(s) - routine vision exams listed in this Rider in *Section 1: Benefits for Routine Vision Examinations.*

Pediatric Dental Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

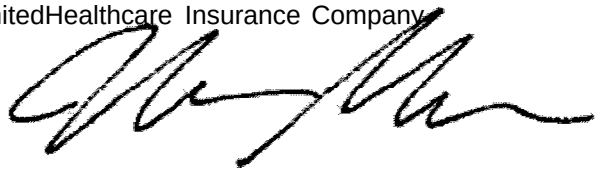
This Rider to the Policy is issued to the Group and provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 5: Defined Terms for Pediatric Dental Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

UnitedHealthcare Insurance Company



William J Golden, President

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from an out-of-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service that is greater than the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can check the participation status by contacting us and/or the provider. We can provide help in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers.* You can also call us at the number stated on your identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from out-of-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary fee. You may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service that is greater than the Usual and Customary fee. When you obtain Covered Dental Services from out-of-Network Dental Providers, you must file a claim with us to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

You are eligible for Benefits for Covered Dental Services listed in this Rider if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service under this Rider.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be given a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Does Pre-Authorization Apply?

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are provided. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

A. Necessary.

B. Provided by or under the direction of a Dental Provider.

C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be given a Benefit based on the least costly procedure.

D. Not excluded as described in *Section 3: Pediatric Dental Exclusions* of this Rider.

Network Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Out-of-Network Benefits:

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of the Usual and Customary fees. You must pay the amount by which the out-of-Network provider's billed charge exceeds the Allowed Dental Amount.

Annual Deductible

Benefits for pediatric Dental Services provided under this Rider are subject to the Annual Deductible stated in the *Schedule of Benefits.*

Out-of-Pocket Limit - any amount you pay in Co-insurance for pediatric Dental Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits.*

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Diagnostic Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation. D0140 - Limited oral evaluation - problem focused. D9995 - Teledentistry - synchronous - real time encounter. D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review. D0150 - Comprehensive oral evaluation. D0180 - Comprehensive periodontal evaluation. The following service is not subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused.	None	50%
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Complete series (including bitewings).	None	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film. D0230 - Intraoral - periapical - each additional film. D0240 - Intraoral - occlusal film.	None	50%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film. D0272 - Bitewings - two films. D0274 - Bitewings - four films. D0277 - Vertical bitewings.	None	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image.	None	50%
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray. D0350 - Oral/Facial photographic images. D0391 - Interpretation of diagnostic image. D0470 - Diagnostic casts.	None	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Preventive Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult. D1120 - Prophylaxis - child.	None	50%
Fluoride Treatments The following services are limited to two times every 12 months. D1206 and D1208 - Fluoride.	None	50%
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth - unrestored permanent molar. D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth.	None	50%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral. D1516 - Space maintainer - fixed - bilateral maxillary. D1517 - Space maintainer - fixed - bilateral mandibular. D1520 - Space maintainer -	None	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
removable - unilateral. D1526 - Space maintainer - removable - bilateral maxillary. D1527 - Space maintainer - removable - bilateral mandibular. D1551 - Re-cement or re-bond bilateral space maintainer - maxillary. D1552 - Re-cement or re-bond bilateral space maintainer - mandibular. D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant. D1556 - Removal of fixed unilateral space maintainer - per quadrant. D1557 - Removal of fixed bilateral space maintainer - maxillary. D1558 - Removal of fixed bilateral space maintainer - mandibular. D1575 - Distal shoe space maintainer - fixed - unilateral - per quadrant.		
Minor Restorative Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent. D2150 - Amalgams - two surfaces, primary or permanent. D2160 - Amalgams - three surfaces,	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
primary or permanent. D2161 - Amalgams - four or more surfaces, primary or permanent.		
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior. D2331 - Resin-based composite - two surfaces, anterior. D2332 - Resin-based composite - three surfaces, anterior. D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior.	40%	50%
Crowns/Inlays/Onlays - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces. D2543 - Onlay - metallic - three surfaces. D2544 - Onlay - metallic - four surfaces. D2740 - Crown - porcelain/ceramic substrate. D2750 - Crown - porcelain fused to high noble metal. D2751 - Crown - porcelain fused to predominately base metal. D2752 - Crown - porcelain fused to noble metal.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D2753 - Crown - porcelain fused to titanium and titanium alloys. D2780 - Crown - 3/4 cast high noble metal. D2781 - Crown - 3/4 cast predominately base metal. D2783 - Crown - 3/4 porcelain/ceramic. D2790 - Crown - full cast high noble metal. D2791 - Crown - full cast predominately base metal. D2792 - Crown - full cast noble metal. D2794 - Crown - titanium and titanium alloys. D2930 - Prefabricated stainless steel crown - primary tooth. D2931 - Prefabricated stainless steel crown - permanent tooth. The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface. D2520 - Inlay - metallic - two surfaces. D2530 - Inlay - metallic - three surfaces. D2910 - Re-cement inlay. D2920 - Re-cement crown.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is not subject to a frequency limit. D2940 - Protective restoration.	50%	50%
The following service is limited to one time per tooth every 60 months. D2929 - Prefabricated porcelain crown - primary. D2950 - Core buildup, including any pins.	50%	50%
The following service is not subject to a frequency limit. D2951 - Pin retention - per tooth, in addition to crown.	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown.	50%	50%
The following service is not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure. D2981 - Inlay repair. D2982 - Onlay repair. D2983 - Veneer repair. D2990 - Resin infiltration/smooth surface.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Endodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration).	40%	50%
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development.	40%	50%
The following service is not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration). D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	40%	50%
The following service is not subject to a frequency limit. D3310 - Anterior root canal (excluding final restoration). D3320 - Bicuspid root canal (excluding final restoration). D3330 - Molar root canal (excluding final restoration). D3346 - Retreatment of previous root canal therapy - anterior. D3347 - Retreatment of previous root canal therapy - bicuspid. D3348 - Retreatment of previous root canal therapy - molar.	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit. D3352 - Apexification/recalcification - interim medication replacement. D3353 - Apexification/recalcification - final visit.	40%	50%
The following service is not subject to a frequency limit. D3354 - Pulpal regeneration.	40%	50%
The following service is not subject to a frequency limit. D3410 - Apicoectomy/periradicular - anterior. D3421 - Apicoectomy/periradicular - bicuspid. D3425 - Apicoectomy/periradicular - molar. D3426 - Apicoectomy/periradicular - each additional root.	40%	50%
The following service is not subject to a frequency limit. D3450 - Root amputation - per root.	40%	50%
The following service is not subject to a frequency limit. D3920 - Hemisection (including any root removal), not including root canal therapy.	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
Periodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more teeth. D4211 - Gingivectomy or gingivoplasty - one to three teeth. D4212 - Gingivectomy or gingivoplasty - with restorative procedures per tooth.	40%	50%
The following service is limited to one every 36 months. D4240 - Gingival flap procedure, four or more teeth. D4241 - Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.	40%	50%
The following service is not subject to a frequency limit. D4249 - Clinical crown lengthening - hard tissue.	40%	50%
The following service is limited to one every 36 months. D4260 - Osseous surgery. D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant. D4263 - Bone replacement graft - first site in quadrant.	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure. D4271 - Free soft tissue graft procedure.	40%	50%
The following service is not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth. D4275 - Soft tissue allograft. D4277 - Free soft tissue graft - first tooth. D4278 - Free soft tissue graft - additional teeth.	40%	50%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant. D4342 - Periodontal scaling and root planing - one to three teeth per quadrant. D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.	40%	50%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis.	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance.	40%	50%
Removable Dentures - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary. D5120 - Complete denture - mandibular. D5130 - Immediate denture - maxillary. D5140 - Immediate denture - mandibular. D5211 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5212 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth). D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth). D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth). D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth). D5282 - Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary. D5283 - Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular. D5284 - Removable unilateral partial denture - one piece flexible base (including clasps and teeth) - per quadrant. D5286 - Removable unilateral partial denture - one piece resin (including clasps and teeth) - per quadrant.	50%	50%
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary. D5411 - Adjust complete denture - mandibular.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D5421 - Adjust partial denture - maxillary. D5422 - Adjust partial denture - mandibular. D5510 - Repair broken complete denture base. D5511 - Repair broken complete denture base - mandibular. D5512 - Repair broken complete denture base - maxillary. D5520 - Replace missing or broken teeth - complete denture. D5610 - Repair resin denture base. D5611 - Repair resin partial denture base - mandibular. D5612 - Repair resin partial denture base - maxillary. D5620 - Repair cast framework. D5621 - Repair cast partial framework - mandibular. D5622 - Repair cast partial framework - maxillary. D5630 - Repair or replace broken retentive/clasping materials - per tooth. D5640 - Replace broken teeth - per tooth. D5650 - Add tooth to existing partial denture. D5660 - Add clasp to existing partial denture.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture. D5720 - Rebase maxillary partial denture. D5721 - Rebase mandibular partial denture. D5730 - Reline complete maxillary denture. D5731 - Reline complete mandibular denture. D5740 - Reline maxillary partial denture. D5741 - Reline mandibular partial denture. D5750 - Reline complete maxillary denture (laboratory). D5751 - Reline complete mandibular denture (laboratory). D5752 - Reline complete mandibular denture (laboratory). D5760 - Reline maxillary partial denture (laboratory). D5761 - Reline mandibular partial denture (laboratory) rebase/reline. D5762 - Reline mandibular partial denture (laboratory). D5876 - Add metal substructure to acrylic full denture (per arch).	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary). D5851 - Tissue conditioning (mandibular).	50%	50%
Bridges (Fixed partial dentures) - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal. D6211 - Pontic - cast predominately base metal. D6212 - Pontic - cast noble metal. D6214 - Pontic - titanium. D6240 - Pontic - porcelain fused to high noble metal. D6241 - Pontic - porcelain fused to predominately base metal. D6242 - Pontic - porcelain fused to noble metal. D6243 - Pontic - porcelain fused to titanium and titanium alloys. D6245 - Pontic - porcelain/ceramic.	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis. D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following services are not subject to a frequency limit. D6519 - Inlay/onlay - porcelain/ceramic. D6520 - Inlay - metallic - two surfaces. D6530 - Inlay - metallic - three or more surfaces. D6543 - Onlay - metallic - three surfaces. D6544 - Onlay - metallic - four or more surfaces.	50%	50%
The following services are limited to one time every 60 months. D6740 - Retainer Crown - porcelain/ceramic. D6750 - Retainer Crown - porcelain fused to high noble metal. D6751 - Retainer Crown - porcelain fused to predominately base metal. D6752 - Retainer Crown - porcelain fused to noble metal. D6780 - Retainer Crown - 3/4 cast high noble metal. D6781 - Retainer Crown - 3/4 cast predominately base metal. D6782 - Retainer Crown - 3/4 cast noble metal. D6783 - Retainer Crown - 3/4 porcelain/ceramic. D6784 - Retainer crown - 3/4 titanium and titanium alloys. D6790 - Retainer Crown - full cast	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
high noble metal. D6791 - Retainer Crown - full cast predominately base metal. D6792 - Retainer Crown - full cast noble metal.		
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond fixed partial denture.	50%	50%
The following services are not subject to a frequency limit. D6973 - Core build up for retainer, including any pins. D6980 - Fixed partial denture repair necessitated by restorative material failure.	50%	50%
Oral Surgery - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root.	40%	50%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring elevation of mucoperioteal flap and removal of bone and/or section of tooth. D7220 - Removal of impacted tooth - soft tissue. D7230 - Removal of impacted tooth - partially bony. D7240 - Removal of impacted tooth - completely bony.	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D7241 - Removal of impacted tooth - completely bony with unusual surgical complications. D7250 - Surgical removal or residual tooth roots. D7251 - Coronectomy - intentional partial tooth removal.		
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	40%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth.	40%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant. D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant. D7320 - Alveoloplasty not in conjunction with extractions - per quadrant. D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant.	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
The following service is not subject to a frequency limit. D7471 - removal of lateral exostosis (maxilla or mandible).	40%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess. D7910 - Suture of recent small wounds up to 5 cm. D7921 - Collect - apply autologous product. D7953 - Bone replacement graft for ridge preservation - per site. D7971 - Excision of pericoronal gingiva.	40%	50%
Adjunctive Services - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure.	40%	50%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes. D9221 - Dental sedation/general anesthesia each additional 15 minutes. D9222 - Deep sedation/general	40%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
anesthesia - first 15 minutes. D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes. D9241 - Intravenous conscious sedation/analgesia - first 30 minutes. D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes. D9610 - Therapeutic drug injection, by report.		
Covered only when clinically Necessary. D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment). D9930 - Treatment of complications (post-surgical) - unusual circumstances by report.	40%	50%
The following is limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch. D9945 - Occlusal guard - soft appliance, full arch. D9946 - Occlusal guard - hard appliance, partial arch.	40%	50%
Implant Procedures - Network and Out-of-Network (Subject to payment of the Annual Deductible.)		
The following services are limited to one time every 60 months. D6010 - Endosteal implant. D6012 - Surgical placement of interim implant body.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6040 - Eposteal implant. D6050 - Transosteal implant, including hardware. D6053 - Implant supported complete denture. D6054 - Implant supported partial denture. D6055 - Connecting bar implant or abutment supported. D6056 - Prefabricated abutment. D6057 - Custom abutment. D6058 - Abutment supported porcelain ceramic crown. D6059 - Abutment supported porcelain fused to high noble metal. D6060 - Abutment supported porcelain fused to predominately base metal crown. D6061 - Abutment supported porcelain fused to noble metal crown. D6062 - Abutment supported cast high noble metal crown. D6063 - Abutment supported cast predominately base metal crown. D6064 - Abutment supported porcelain/ceramic crown. D6065 - Implant supported porcelain/ceramic crown. D6066 - Implant supported crown - porcelain fused to high noble alloys. D6067 - Implant supported crown - high noble alloys.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture. D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture. D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture. D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture. D6072 - Abutment supported retainer for cast high noble metal fixed partial denture. D6073 - Abutment supported retainer for predominately base metal fixed partial denture. D6074 - Abutment supported retainer for cast metal fixed partial denture. D6075 - Implant supported retainer for ceramic fixed partial denture. D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys. D6077 - Implant supported retainer for metal FPD - high noble alloys. D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch. D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch. D6080 - Implant maintenance procedure.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure. D6082 - Implant supported crown - porcelain fused to predominantly base alloys. D6083 - Implant supported crown - porcelain fused to noble alloys. D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys. D6086 - Implant supported crown - predominantly base alloys. D6087 - Implant supported crown - noble alloys. D6088 - Implant supported crown - titanium and titanium alloys. D6090 - Repair implant prosthesis. D6091 - Replacement of semi-precision or precision attachment. D6095 - Repair implant abutment. D6096 - Remove broken implant retaining screw. D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys. D6098 - Implant supported retainer - porcelain fused to predominantly base alloys. D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys.		

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D6100 - Implant removal. D6101 - Debridement peri-implant defect. D6102 - Debridement and osseous peri-implant defect. D6103 - Bone graft periimplant defect. D6104 - Bone graft implant replacement. D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular. D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary. D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys. D6121 - Implant supported retainer for metal FPD - predominantly base alloys. D6122 - Implant supported retainer for metal FPD - noble alloys. D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys. D6190 - Implant index. D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys.		

Medically Necessary Orthodontics - Network and Out-of-Network (Subject to payment of the Annual Deductible.)

Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, *Crouzon's Syndrome, Treacher-Coll ins Syndrome, Pierre-Robin Syndrome,* hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
spacing between teeth, temporomandibular joint *(TMJ)* conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition. D8020 - Limited orthodontic treatment of the transitional dentition. D8030 - Limited orthodontic treatment of the adolescent dentition. D8050 - Interceptive orthodontic treatment of the primary dentition. D8060 - Interceptive orthodontic treatment of the transitional dentition. D8070 - Comprehensive orthodontic treatment of the transitional dentition. D8080 - Comprehensive orthodontic treatment of the adolescent dentition. D8090 - Comprehensive orthodontic treatment of the adult dentition. D8210 - Removable appliance therapy. D8220 - Fixed appliance therapy.	50%	50%

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits - The Amount You Pay Which May Include a Co-insurance or Co-Payment.**	**Out-of-Network Benefits - The Amount You Pay Which is Shown as a Percentage of Allowed Dental Amounts.**
D8660 - Pre-orthodontic treatment visit. D8670 - Periodic orthodontic treatment visit. D8680 - Orthodontic retention. D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment. D8696 - Repair of orthodontic appliance - maxillary. D8697 - Repair of orthodontic appliance - mandibular.		
D8698 - Re-cement or re-bond fixed retainer - maxillary. D8699 - Re-cement or re-bond fixed retainer - mandibular. D8701 - Repair of fixed retainer, includes reattachment - maxillary. D8702 - Repair of fixed retainer, includes reattachment - mandibular.		

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Pediatric Dental Services,* Benefits are not provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Pediatric Dental Services.*
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges. This exclusion does not apply to Benefits provided under *Dental Services - Hospital or Alternate Facility/Anesthesia* in *Section 1: Covered Health Care Services* of the *Certificate.*
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

5. Reconstructive surgery, regardless of whether or not the surgery is related to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Care Services* of the *Certificate.*

6. Any Dental Procedure not directly related with dental disease.

7. Any Dental Procedure not performed in a dental setting.

8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics.* The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

9. Drugs/medications, received with or without a prescription, unless they are dispensed and used in the dental office during the patient visit.

10. Setting of facial bony fractures and any treatment related with the dislocation of facial skeletal hard tissue. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Care Services* of the *Certificate.*

11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Care Services* of the *Certificate.*

12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.

14. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this Rider to the Policy.

15. Dental Services otherwise covered under the Policy, but provided after the date individual coverage under the Policy ends, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy ends.

16. Services rendered by a provider with the same legal residence as you or who is a member of your family, including spouse, brother, sister, parent or child.

17. Foreign Services are not covered unless required as an Emergency.

18. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. This exclusion does not apply to Benefits provided under *Orthognathic Surgery* in *Section 1: Covered Health Care Services* of the *Certificate.*

19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion *(VDO).*

20. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

23. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. This exclusion does not apply to Benefits provided under *Orthognathic Surgery* in *Section 1: Covered Health Care Services* of the *Certificate.*

Section 4: Claims for Pediatric Dental Services

When receiving Dental Services from an out-of-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information shown below.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services provided before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate:*

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Allowed Dental Amounts are our contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from Out-of-Network Dental Providers, Allowed Dental Amounts are the Usual and Customary fees, as defined below.

Covered Dental Service - a Dental Service or Dental Procedure for which Benefits are provided under this Rider.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide Dental Services, perform dental surgery or provide anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Necessary - Dental Services and supplies under this Rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Covered Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health.*

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Usual and Customary - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology* (publication of the *American Dental Association).*
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that we accept.

Pediatric Vision Care Services Rider

UnitedHealthcare Insurance Company

How Do You Use This Document?

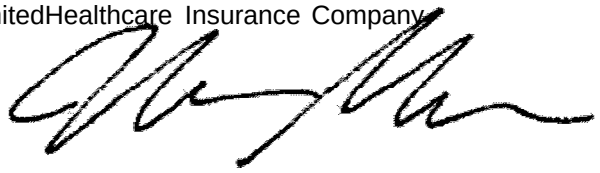
This Rider to the Policy is issued to the Group and provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider will end on the last day of the month the Covered Person reaches the age of 19.

What Are Defined Terms?

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

UnitedHealthcare Insurance Company



William J Golden, President

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or out-of-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek payment from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Pediatric Vision Care Services.* Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Co-payments at the time of service.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Network Benefits:

Benefits for Vision Care Services from out-of-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Limit - any amount you pay in Co-insurance for Vision Care Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits.* Any amount you pay in Co-payments for Vision Care Services under this Rider applies to the Out-of-Pocket Limit stated in the *Schedule of Benefits.*

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Rider are not subject to any Annual Deductible stated in the *Schedule of Benefits.* Any amount you pay in Co-payments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the *Schedule of Benefits.*

What Are the Benefit Descriptions?

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Co-payments and Co-insurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Exam

A routine vision exam of the eyes and according to the standards of care in your area, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point of convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).

- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) - helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing - far and near (how well eyes work as a team).
- Tests of accommodation - how well you see up close (for example, reading).
- Tonometry, when indicated - test pressure in eye (glaucoma check).
- Ophthalmoscopic exam of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations. Lenses include a choice of glass, plastic or polycarbonate.

You are eligible to choose only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to choose only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

If you purchase *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks Vision Care Provider, only one Co-payment will apply to those *Eyeglass Lenses* and *Eyeglass Frames* together.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

You are eligible to choose only one of either eyeglasses *(Eyeglass Lenses* and/or *Eyeglass Frames)* or *Contact Lenses.* If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Routine Vision Exam or Refraction only in lieu of a complete exam	Once every calendar year.	None Not subject to payment of the Annual Deductible.	50% of the billed charge.
Eyeglass Lenses	Once every calendar year.		
• Single Vision		None Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Bifocal		None Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Trifocal		None Not subject to payment of the Annual Deductible.	50% of the billed charge.
• Lenticular		None Not subject to payment of the Annual Deductible.	50% of the billed charge.
Lens Extras			
• Polycarbonate lenses	Once every calendar year.	None Not subject to payment of the Annual Deductible.	50% of the billed charge.

• Standard scratch-resistant coating	Once every calendar year.	None Not subject to payment of the Annual Deductible.	None
Each of the following is a separate charge shown under the Network Benefit: • Blended Segment Lenses • Intermediate Vision Lenses • Standard Progressives • Premium Progressives • Photochromic Glass • Plastic Photosensitive Lenses • Polarized Lenses • Hi-Index Lenses • Standard Anti-Reflective Coating • Ultra Anti-Reflective Coating Fashion and gradient tinting Ultraviolet Protective Coating Oversized and glass-grey #3 prescription sunglass lenses	Once every calendar year.	80% of the billed charge.	80% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Eyeglass Frames	Once every calendar year.		
• Eyeglass frames		None Not subject to payment of the Annual Deductible.	50% of the billed charge.

Vision Care Service	What Is the Frequency of Service?	Network Benefit - The Amount You Pay Based on the Contracted Rate	Out-of-Network Benefit - The Amount You Pay Based on Billed Charges
Contact Lenses and Fitting & Evaluation			
• Contact Lens Fitting & Evaluation	Limited to a 12 month supply.	None Not subject to payment of the Annual Deductible.	None
• Covered Contact Lens Selection	Limited to a 12 month supply.	None Not subject to payment of the Annual Deductible.	50% of the billed charge.
Necessary Contact Lenses	Limited to a 12 month supply.	None	50% of the billed charge.
Low Vision Care Services: Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months		
• Low vision testing		None	50% of billed charges.
• Low vision therapy		25% of billed charges .	50% of billed charges.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services,* Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Certificate.*
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Pediatric Vision Care Services.*
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services provided by a non-Spectera Eyecare Networks Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not provided by a Spectera Eyecare Networks Vision Care Provider or an out-of-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Send the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate:*

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this Rider in *Section 1: Benefits for Pediatric Vision Care Services.*

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms.*

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Care Services described in the *Certificate.*

UnitedHealthcare Insurance Company

William J Golden, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee makes tier placement changes on our behalf. The PDL Management Committee places FDA-approved Prescription Drug Product into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations of the cost effectiveness of the Prescription Drug Product.

We may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

NOTE: The tier placement of a Prescription Drug Product may change, from time to time, based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim.* When you submit a claim on this basis, you may pay more because you did not verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Co-payment and/or Co-insurance, Ancillary Charge and any deductible that applies.

Submit your claim to:

Optum Rx

PO Box 29077

Hot Springs, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at www.myuhc.com or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid.

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty

Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program,* by contacting us at www.myuhc.com or the telephone number on your ID card.

Smart Fill Program - 90-Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Co-payment and/or Co-insurance will reflect the number of days dispensed. The *Smart Fill Program* offers a 90-day supply of certain Specialty Prescription Drug Products if you are stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program.* You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, by contacting us at www.myuhc.com or the telephone number on your ID card.

When Do We Limit Selection of Pharmacies?

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, we may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date we notify you, we will choose a Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting any applicable deductible. As determined by us, we may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Co-payment and/or Co-insurance.

We, and a number of our affiliated entities, conduct business with pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider.* Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider.* We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or taking part in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at www.myuhc. com or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at a Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit by contacting us at www.myuhc.com or the telephone number on your ID card.

Refill Synchronization

We have a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. You may access information on these procedures through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Benefits for Refills for Prescription Eye Drops to Treat Glaucoma or Ocular Hypertension

Benefits include refills of a prescription for eye drops to treat glaucoma or ocular hypertension if the following apply:

- You request the refill:
  - For a 30-day supply, at least 23 days but not less than 33 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
  - For a 60-day supply, at least 45 days but not less than 60 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
  - For a 90-day supply, at least 68 days but not less than 90 days from the later of:
    - The original date the prescription was distributed to you.
    - The date of the most recent refill was distributed to you.
- The eye drops to treat glaucoma or ocular hypertension prescribed by the provider are a Covered Health Care Service under the Policy.
- The prescribing provider indicates on the original prescription that additional quantities of the eye drops are needed.
- The refill requested by you does not exceed the number of additional quantities prescribed.

Outpatient Prescription Drug Rider Table of Contents

Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Co-payments and/or Co-insurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception. Benefits are also available for PPACA Zero-Cost Preventive Care Medications as defined in *Section 3: Defined Terms* and include, but are not limited to:

- FDA-approved smoking cessation aids and/or drug products both prescribed and over-the-counter. You must have a Prescription Order in order to receive Benefits.
- Over-the-counter aspirin in accordance with the current recommendations of the *United States Preventive Services Task Force* and prescribed by a Network provider.
- Over-the-counter contraceptives for women when prescribed by a licensed health care professional in accordance with the current recommendations of the *United States Preventive Services Task Force* and as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*
- All other *United States Preventive Services Task Force* "A" and "B" recommended over-the-counter medications and supplements when prescribed by a Network provider. You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at **http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations.** If you do not have internet access, please contact us at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, and you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you will be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how Specialty Prescription Drug Product supply limits apply.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail Network Pharmacy supply limits apply.

Depending upon your plan design, this *Outpatient Prescription Drug Rider* may offer limited Network Pharmacy providers. You can confirm that your pharmacy is a Network Pharmacy by calling the telephone number on your ID card or you can access a directory of Network Pharmacies online at www.myuhc.com.

Prescription Drugs from a Retail Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail out-of-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim.* We will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how retail out-of-Network Pharmacy supply limits apply.

Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

The *Outpatient Prescription Drug Schedule of Benefits* will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply.

Please contact us at www.myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact us at www.myuhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. The exclusion will not limit or exclude coverage for any prescription drug approved by the *U.S. Food and Drug Administration (FDA)* prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the *United States Food and Drug Administration* for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia.
    - The acceptable standard medical reference compendia are the following:
        - The *American Hospital Formulary Service Drug Information,* a publication of the *American Society of Health System Pharmacists.*
        - The *National Comprehensive Cancer Network Drugs and Biologics Compendium.*
        - *Thomson Micromedex Compendium DRUGDEX.*
        - *Elsevier Gold Standard's Clinical Pharmacology Compendium.*
        - Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services.*
    - Medical literature may be accepted if all of the following apply:
        - At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
        - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
        - The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors,* or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B).
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate.* Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
11. Certain unit dose packaging or repackagers of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Prescription Drug Products when prescribed to treat infertility. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the *Certificate.*
16. Treatment for toenail Onychomycosis (toenail fungus).
17. Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* in order to comply with essential health benefits requirements.
18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier 4.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter aids and/or drugs used for smoking cessation, aspirin or over-the-counter contraceptives for women for which Benefits are available as described in *Section 1: Benefits for Prescription Drug Products.*
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
21. Any oral non-sedating antihistamine or antihistamine-decongestant combination.
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except for Eosinophilic Gastrointestinal Disorder Formula or for Medical Foods prescribed for the treatment of Inherited Metabolic Disorder in *Section 3: Defined Terms* of this *Rider.*

23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

26. Certain Prescription Drug Products that have not been prescribed by a Specialist.

27. A Prescription Drug Product that contains marijuana, including medical marijuana.

28. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the *Patient Protection and Affordable Care Act (PPACA)* essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

29. Dental products, including but not limited to prescription fluoride topicals.

30. A Prescription Drug Product with either:

    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

31. Diagnostic kits and products.

32. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

33. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge for the Chemically Equivalent Prescription Drug Product.

For Prescription Drug Products from out-of-Network Pharmacies, the Ancillary Charge is the difference between:

- The Out-of-Network Reimbursement Rate for the Prescription Drug Product.
- The Out-of-Network Reimbursement Rate for the Chemically Equivalent Prescription Drug Product.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician will be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Eosinophilic Gastrointestinal Disorder Formula - amino acid-based formula used in the treatment of a Covered Person who has been diagnosed as having an eosinophilic gastrointestinal disorder, subject to the following conditions:

- The Covered Person must be under the continuous supervision of a Physician who is licensed under Title 32, Chapter 13 or 17 of the Arizona Revised Statutes or a registered nurse practitioner who is licensed under Title 32, Chapter 15 of the Arizona Revised Statutes.
- The formula must be prescribed or ordered by a Physician or a registered nurse practitioner.
- There must be a risk of mental or physical impairment to the Covered Person without the use of the formula.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources. This includes, data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician will be classified as a Generic by us.

Inherited Metabolic Disorder - a disease or disorder caused by an inherited abnormality of body chemistry, including a disease or disorder tested under the newborn screening program:

- Which involves amino acid, carbohydrate and fat metabolism.
- For which medically standard methods of diagnosis, treatment, and monitoring exist.
- Which requires specifically processed or treated Medical Foods that are generally available only under the supervision and direction of a Physician or a registered nurse practitioner with special training in the diagnosis and treatment of patients with genetic inborn errors of metabolism and that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may find the List of Preventive Medications by contacting us at www.myuhc.com or the telephone number on your ID card.

Maintenance Medication - a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. You may find out if a Prescription Drug Product is a Maintenance Medication by contacting us at www.myuhc.com or the telephone number on your ID card.

Maximum Allowable Amount - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our review and change from time to time.

Medical Foods - modified nutritional substances in any form that are all of the following:

- Used in the treatment of Inherited Metabolic Disorders to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- Formulated to be consumed or administered enterally under the supervision of a Physician or a registered nurse practitioner.
- Specifically processed or formulated to be deficient in one or more nutrients present in typical foodstuffs. This does not include a natural food or food product that is naturally low in protein.
- Intended for the medical and nutritional management of patients who have limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation.
- Essential to optimize growth, health, and metabolic homeostasis.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is placed on a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a non-preferred pharmacy within the Network.

Out-of-Network Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives by contacting us at www.myuhc.com or the telephone number on your ID card.

Preferred 90 Day Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network for Maintenance Medication.

Preferred Specialty Network Pharmacy - a specialty pharmacy that we identify as a preferred pharmacy within the Network.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA).* The Prescription Drug List is developed through an evidence-based evaluation when determining which Prescription Drug Products are covered or excluded under the Policy. Medications may be excluded from coverage when it works the same or similar as another prescription medication or an over-the-counter medication. This list is subject to our review and change from time to time. You may find out to which tier a particular Prescription Drug Product has been placed by contacting us at www.myuhc.com or the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for placing Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- The following diabetic supplies:
  - blood glucose monitors;
  - blood glucose monitors for the legally blind;
  - test strips for glucose monitors and visual reading and urine testing strips;
  - insulin preparations and glucagon;
  - insulin cartridges;
  - drawing up devices and monitors for the visually impaired;
  - injection aids;
  - insulin cartridges for the legally blind;
  - syringes and lancets, including automatic lancing devices;
  - prescribed oral agents for controlling blood sugar; and
  - any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products by contacting us at www.myuhc.com or the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Section 4: Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Please note, if your request for an exception is approved by us, you may be responsible for paying the applicable Co-payment and/or Co-insurance based on the Prescription Drug Product tier placement as described in the *Benefit Information* table in the *Outpatient Prescription Drug Schedule of Benefits,* in addition to any applicable Ancillary Charge.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The Independent Review Organization (IRO) will notify you of our determination within 72 hours.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The IRO will notify you of our determination within 24 hours.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or an out-of-Network Pharmacy and are subject to Co-payments and/or Co-insurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate of Coverage,* regardless of tier placement.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting us at www.myuhc.com or the telephone number on your ID card.

Do Prior Authorization Requirements Apply?

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Care Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at an out-of-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to our review and change. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may find out whether a particular Prescription Drug Product requires notification/prior authorization by contacting us at www.myuhc.co m or the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at an out-of-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim.*

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Co-payment and/or Co-insurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Care Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits related to such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements related to such programs by contacting us at www.myuhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at www.myuhc.com or the telephone number on your ID card.

What Do You Pay?

You are responsible for paying the applicable Co-payment and/or Co-insurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Limit stated in your *Certificate:*

- Ancillary Charges.
- The difference between the Out-of-Network Reimbursement Rate and an out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. Our contracted rates (our Prescription Drug Charge) will not be available to you.

Prescription Drug Product Cost Sharing Accumulation

Any Co-payment, Co-insurance, or other applicable cost sharing requirement for pharmacy benefits paid by the enrollee or another person on behalf of the enrollee will contribute toward the calculation of an enrollee's Out-of-Pocket Limit and deductible.

Payment Information

Payment Term And Description	Amounts
Co-payment and Co-insurance	
Co-payment Co-payment for a Prescription Drug Product at a Network or out-of-Network Pharmacy is a specific dollar amount. ***Co-insurance*** Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge. Co-insurance for a Prescription Drug Product at an out-of-Network Pharmacy is a percentage of the Out-of-Network Reimbursement Rate. ***Co-payment and Co-insurance*** Your Co-payment and/or Co-insurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product. We may cover multiple Prescription Drug Products for a single Co-payment and/or Co-insurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. Your Co-payment and/or Co-insurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs by contacting us at www.myuhc.com or the telephone number on your ID card.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following: • The applicable Co-payment and/or Co-insurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: • The applicable Co-payment and/or Co-insurance. • The Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts. You are not responsible for paying a Co-payment and/or Co-insurance for PPACA Zero Cost Share Preventive Care Medications.

Payment Term And Description	Amounts
Your Co-payment and/or Co-insurance for insulin will not exceed the amount allowed by applicable law. **Special Programs:** We may have certain programs in which you may receive a reduced or increased Co-payment and/or Co-insurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may access information on these programs by contacting us at www.myuhc.com or the telephone number on your ID card. **Co-payment/Co-insurance Waiver Program:** If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Co-payment and/or Co-insurance for one or more Prescription Orders or Refills. **Prescription Drug Products Prescribed by a Specialist:** You may receive a reduced or increased Co-payment and/or Co-insurance based on whether the Prescription Drug Product was prescribed by a Specialist. You may access information on which Prescription Drug Products are subject to a reduced or increased Co-payment and/or Co-insurance by contacting us at www.myuhc.com or the telephone number on your ID card. **NOTE:** The tier status of a Prescription Drug Product can change from time to time. These changes generally happen quarterly but no more than six times per calendar year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact us at www.myuhc.com or the telephone number on your ID card for the most up-to-date tier status.	

Payment Term And Description	Amounts
Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers or an affiliate to reduce your Co-payment and/or Co-insurance.	

Benefit Information

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	What Is the Co-payment or Co-insurance You Pay? **This May Include a Co-payment, Co-insurance or Both**
Eosinophilic Gastrointestinal Disorder Formula	
Benefits for Eosinophilic Gastrointestinal Disorder Formula are subject to payment of the Annual Drug Deductible in high deductible health plans only.	You pay 25% of the Prescription Drug Charge per Prescription Order or Refill for Eosinophilic Gastrointestinal Disorder Formula.
Medical Foods	
Benefits for Medical Foods are subject to payment of the Annual Drug Deductible in high deductible health plans only.	You pay 50% of the Prescription Drug Charge per Prescription Order or Refill for Medical Foods to treat an Inherited Metabolic Disorder.
Specialty Prescription Drug Products	
The following supply limits apply. • As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed. We designate certain Network Pharmacies to be Preferred Specialty Network	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier placement. ***Preferred Specialty Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: 50% of the Prescription Drug Charge per Prescription Order or Refill.

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Pharmacies. We may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to you unless required by law. You may determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy by contacting us at www.myuhc.com or by the telephone number on your ID card. If you choose to obtain your Specialty Prescription Drug Product from a Non-Preferred Specialty Network Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.	For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. ***Non-Preferred Specialty Network Pharmacy*** You will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier. ***Out-of-Network Pharmacy*** For a Tier 1 Specialty Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 2 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product: 50% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. For a Tier 4 Specialty Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.
Prescription Drugs from a Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 50% of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.
Prescription Drugs from a Retail Out-of-Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Co-payment and/or Co-insurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Co-payment	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
and/or Co-insurance that applies will reflect the number of days dispensed or days the drug will be delivered.	Medications: $5 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 50% of the Out-of-Network Reimbursement Rate per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill.
Prescription Drug Products from a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy	
The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading *Specialty Prescription Drug Products.* You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Co-payment and/or Co-insurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy or Preferred 90 Day Retail Network Pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.	Your Co-payment and/or Co-insurance is determined by the PDL Management Committee's tier placement the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2, Tier 3 or Tier 4. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status. For up to a 31-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $10 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $35 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $90 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 50% of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $5 per Prescription Order or Refill. For up to a 60-day supply at a mail order Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $20 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.	
Description and Supply Limits	**What Is the Co-payment or Co-insurance You Pay?** **This May Include a Co-payment, Co-insurance or Both**
	Medications: $10 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $70 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $180 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 50% of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $10 per Prescription Order or Refill. For up to a 90-day supply at a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you pay: For a Tier 1 Prescription Drug Product: $25 per Prescription Order or Refill. For a Tier 1 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: $87.50 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: $225 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 50% of the Prescription Drug Charge per Prescription Order or Refill. For a Tier 4 Prescription Drug Product on the List of Preventive Medications: $12.50 per Prescription Order or Refill.

LANGUAGE ASSISTANCE SERVICES

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card TTY/RTT711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCION: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर कॉल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે ગુજરાતી **(Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.

કૃપા કરી 1-866-633-2446 પર કોલ કરો.

NOTICE OF NON-DISCRIMINATION

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY/RTT711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1] For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998,* Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Care Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Care Services (including Co-payments, Co-insurance and any deductible) are the same as are required for any other Covered Health Care Service. Limitations on Benefits are the same as for any other Covered Health Care Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement according to the applicable claim filing procedures. If you pay a Co-payment and believe that the amount of the Co-payment was incorrect, you also may submit a claim for reimbursement according to the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one-time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits according to the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information.
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally call us at the telephone number on your ID card before requesting a formal appeal. If the representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a representative. If you first informally contact us and later wish to request a formal appeal in writing, you should again contact us and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact us immediately.

How Do You Appeal a Claim Decision?

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial of pre-service request for benefits or a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits. However, if your state requires two levels of appeal, the first level appeal will take place and you will be notified of the decision within 15 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service claims as shown above, the first level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. However, if your state requires two levels of appeal, the first level appeal will take place and your will be notified of the decision within 30 days.

  If your state requires a second level appeal, it must be submitted to us within 60 days from the receipt of the first level appeal decision. The second level appeal will take place and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures related to urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require urgent action if a delay in treatment could increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information. The appeal process for urgent situations does not apply to prescheduled treatments, therapies, or surgeries.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2021:

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services,* if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- For Communications to You. We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us. We may communicate certain health information in these messages via unencrypted methods. These communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved with Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us, and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown in our contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information

is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your health plan website, such as www.myuhc.co m.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may call us at 1-866-633-2446 or TTY/RTT711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; National Foundation Life Insurance Company; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain HealthCare Options, Inc.; Sierra Health and Life Insurance Company, Inc.; Symphonix Health Insurance, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2021

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communicati ons on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or call us at 1-866-633-2446 or TTY/RTT711.

[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: AmeriChoice Corporation.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; LifePrint East Inc.; LifePrint Health, Inc.; Managed Physical Network, Inc.; Medication Management dba Genoa Medication Management Solutions; Optum Global Solutions (India) Private Limited; Optum Health Care Solutions, Inc.; Optum Networks of New Jersey, Inc.; Optum Women's and Children's Health LLC, LLC; OrthoNet, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, Inc.; Renai Health IPA, LLC Renai Health Management, LLC; Sanvello Health, Inc.; Savvysherpa Administrative Services, LLC; Spectera, Inc.; Three Rivers Holdings, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United

HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA).*

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration.*

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description.* The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA.*

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA,* there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor,* or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor,* 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*